Healthy People. A Healthy Province.

The Action Plan for Saskatchewan Health Care

The Action Plan

Highlights

- Establish primary health care teams of doctors, nurses, and other health providers.
- Create a 24-hour toll-free telephone line offering immediate access to health advice.
- Create a province-wide network of community, northern, district, regional, and provincial hospitals. This plan does not close or convert any hospitals.
- Provide more funding to reduce waiting times for surgery.
- Provide $3 million in new funding to train more health providers and to offer return-service bursaries for students studying in selected health programs.
- Provide funding to train 240 new or existing ambulance attendants to become emergency medical technicians.
- Reduce administration and improve planning with the formation of 12 Regional Health Authorities to replace 32 districts.
- Create Canada's first Quality Council, to promote excellence and effective health spending.
- Increase support for health research by 40 per cent in the 2002-03 budget by adding $2 million to the $5 million invested this year, with further increases to follow.

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The Action Plan

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A Message from the Premier of Saskatchewan and the Minister of Health

We are pleased to present *The Action Plan for Saskatchewan Health Care*, our blueprint to secure the future of health services in our province.

This health plan is the result of many months of careful study and consultation. We have built on the findings of the Fyke Commission on Medicare and the Saskatchewan Legislature's Standing Committee on Health Care. We have listened to people from across our province about the services that matter to them and their families, and about how we can make those services better.

Our government will take a strong leadership role in making the changes needed. Our top priority is improving the quality of services and access to care, while ensuring our health system is sustainable into the future.

We believe in a health system that cares for the people it serves, that provides care regardless of people's ability to pay, that supports and values our health providers, that offers timely, quality treatment, and that promotes health and well-being.

One of the most encouraging things we heard during our government's consultations is that Saskatchewan people have a strong and enduring belief in a publicly funded health system. People are proud of our public Medicare system, created here in Saskatchewan four decades ago. They want to improve and strengthen it for the future, but recognize that this will require change.

We heard clearly, however, that people are not looking for dramatic change that would disrupt the services in their communities. They want secure access to doctors, hospitals, emergency care, and other vital services.

Accordingly, our health plan calls for a practical, balanced approach to change, at a manageable pace.

To achieve this, we have drawn on some of the best ideas from the Fyke report aimed at improving the way we deliver everyday front-line services while achieving the best value for our health dollar. At the same time, we have rejected some of the more disruptive recommendations, such as the conversion of up to 50 rural hospitals.

Our health plan focuses on attracting the doctors, nurses, and other health providers we need. It strives to reduce waiting times for surgery and improve the fairness and transparency of the surgical system. It improves the delivery of everyday health services in our communities. It sets out a new framework for accountability that will ensure the most effective use of our health dollars. And, it focuses on supporting good health for every resident of our province.

In the months ahead, our government will work closely with health care providers and the public to begin making the changes outlined in this health plan. Together, we will build a renewed sense of pride in our health care system.

Lorne Calvert
Premier of Saskatchewan

John T. Nilson, Q.C.
Minister of Health

The Action Plan

This is a health plan with a clear purpose: building a province of healthy people and healthy communities.

Every day in Saskatchewan, thousands of people receive the care they need to support their health and well-being. Surveys tell us that most Saskatchewan residents are quite satisfied with their care.

The providers who work in our health system are dedicated to their jobs and the people they serve. Whether they are giving flu shots or performing complex surgery, our health care workers provide exceptional care.

Overview

But our system also has its shortcomings. Like many other places, we are experiencing shortages of key health professionals. Waiting times for some surgeries and diagnostic tests are too long.

Another concern is the rapid growth in health care costs. Every year, we see exciting medical advances that add quality and years to people's lives. However, they come at a high cost. As our population grows older, and more people require costly medications and treatments, the pressure mounts on Saskatchewan's health care budget.

Saskatchewan people are living longer, healthier lives than ever before. Still, there are some troubling issues we are working to address. Our province has a high incidence of chronic conditions such as diabetes and high blood pressure. We also have an unacceptably high infant mortality rate.

Across Canada, people are looking for solutions to many of the same problems. Governments have increased spending on health services, and yet the problems remain. This points to the need for change in the way we think about and deliver health services.

With all of these considerations in mind, the Saskatchewan government launched a major review of the health system in June 2000. The Saskatchewan Commission on Medicare, headed by health consultant Ken Fyke, issued its report on April 11, 2001. The government invited comments from the public and health care providers, and more than 100 individuals and organizations appeared before the Standing Committee on Health. Many others have shared their views with the Minister of Health, MLAs, and health officials.

This health plan draws upon the best ideas and innovations from the Fyke report. It proposes a more effective way of organizing and delivering basic, front-line health services. It embraces quality and efficiency measures to ensure we receive high standards of care and top value for our health dollars. Most importantly, this plan supports the Fyke Commission's conclusion that a publicly funded Medicare system is the fairest, most efficient way of delivering health care.

However, this health plan also parts company with the Fyke report on some significant issues.

Saskatchewan people are not looking for dramatic changes that would disrupt the delivery of health services to their communities. They are concerned about changes that would reduce access to hospital, emergency or physician services. We heard the public and our plan addresses their concerns. This health plan contains changes to make our hospital system more efficient, but does not close or convert any facilities.

While there are differing views on how to address the challenges in health, there is strong agreement that Saskatchewan needs a comprehensive plan that sets a clear direction for the future delivery of health services.

This health plan will change the way health services are delivered in Saskatchewan, at a manageable pace. The change will focus on four main areas:

- doing more to support good health and prevent illness;
- providing better access to health services, including primary, hospital, and emergency care;
- improving health workplaces and addressing shortages of key health providers; and
- placing a greater emphasis on quality, efficiency and accountability, in order to ensure the long-term sustainability of our Medicare system.

SUPPORTING HEALTH PROMOTION AND DISEASE PREVENTION

For some families, there are underlying problems that interfere with good health. People have a harder time remaining healthy when they do not have adequate income, housing, education, or support from family and friends.

This health plan recognizes the importance of putting more emphasis on the underlying factors that influence a person's health status. Saskatchewan Health will work with newly created Regional Health Authorities on a health promotion strategy that targets programs and funding to where they will be most successful. Future investments in health promotion initiatives will support the work of Regional Health Authorities and other community agencies in implementing this province-wide strategy.

Northern and Aboriginal Health

Northern and Aboriginal communities have their own issues and concerns around health care. They also have a unique perspective on how to bring better health care to their people.

Leaders from the northern health districts and the Northern Inter-Tribal Health Authority are working on a Northern Health Strategy that is built on principles developed by and for northern residents. Our government supports the development of a Northern Health Strategy that is based on the principles of health promotion and disease prevention and recognizes the North's unique languages, culture, history, and geography.

Primary health care services will be expanded in partnership with First Nations and Metis peoples. Our government will pursue additional funding from the federal Primary Health Transition Fund to support primary care for Aboriginal people living on- and off-reserve.

IMPROVING ACCESS TO HEALTH SERVICES

Primary health care covers everything from the diagnosis of common illnesses to the treatment of minor injuries and the management of ongoing problems like asthma, diabetes, high blood pressure, or anxiety.

Primary health care is the first and most frequent point of contact people have with the health system. It is essential for these services to be organized and delivered in the most effective way possible. This health plan calls for the development of primary health care teams, where doctors, nurses, therapists and other front-line providers work together to meet the needs of patients.

Primary health care networks will be developed in the Regional Health Authorities, and will offer a full range of everyday health services. Our goal is that once these networks are fully established, all communities will have access to primary health care within 30 minutes. These networks will be supported by a 24-hour telephone line that people can call for convenient, immediate health information and advice.

Primary health care teams will play an important role in preventing health problems and managing existing ones, so they do not become more serious.

Hospital Services

To ensure reliable access to hospital services, Saskatchewan needs a strong network of hospitals in all areas of the province. This plan calls for five provincial hospitals located in Regina and Saskatoon, six regional hospitals, nine district hospitals, four northern hospitals, and 44 community hospitals. Classifying hospitals in this way allows facilities to focus on their strengths, and provides patients and health providers with a clearer understanding of which services are available in which facilities.

Community hospitals hold an important place in the delivery of health care and the success of rural communities. Community hospitals will offer 24-hour emergency services, general medicine, basic lab and x-ray services, and observation, assessment, convalescent and palliative care.

This plan does not call for any hospital closures or conversions. However, it does recognize that as our health care system and communities evolve, there will be ongoing service changes to reflect changing populations or service needs. Where a change is contemplated, government, Regional Health Authorities and communities will work closely together to evaluate the care that is needed and how it can be best provided.

We will support four northern hospitals including the new facility in Stony Rapids, which is currently under construction.

District hospitals will be established in nine communities with a larger population base and the ability to support a broader range of services. District hospitals will provide a minimum standard of service that includes 24-hour emergency care, general medical

services for adults and children, low complexity surgeries and low-risk baby deliveries.

Regional hospitals in six mid-sized cities will provide the next level of specialty services. These centres will offer general surgery, obstetrics and more advanced diagnostic services, with a goal of maintaining three doctors with advanced training in each specialty area. The largest regional hospitals, located in Prince Albert and Moose Jaw, will work to provide an even wider range of services.

Provincial hospitals in Regina and Saskatoon provide a full-range of specialized medical, surgical and diagnostic services. To improve access to these specialized services for all residents of our province, this health plan calls for funding increases to the provincial hospitals, with the amounts to be determined through the budget process.

Surgical Waiting Times

Saskatchewan people want action to reduce surgical waiting times. Experience tells us that the only way to make real progress is to tackle the problem on several fronts. This plan includes the following actions to reduce waiting times:

- a commitment to increased operating funding for the surgical centres;
- a province-wide surgical waiting list, with guidelines to ensure the people who need surgery the most receive it first;
- programs to keep and attract key health providers; and
- a web site and key contact people to answer questions about waiting lists.

Ambulance Services

In an emergency, patients receive care the minute the ambulance arrives. The skills of the attendant are important, so we will train 240 new or existing emergency medical service providers to become certified emergency medical technicians over the next three years.

Centralizing the dispatch of ambulances to five communication call centres will help to improve the co-ordination and efficiency of ambulance services throughout our province. Over time we will examine the potential advantages of even fewer call centres.

Patients share in the cost of ambulance trips, but the cost they pay varies across the province. To ensure greater consistency of ambulance charges, we will regulate fees and, as resources allow, reduce the patient fee for transfers between hospitals.

Long-term Care

Most seniors and people with disabilities would prefer to remain independent in their communities as long as possible. This health plan will provide more opportunity for them to do so by allowing for the expansion of personal care homes, providing supports to more seniors who live in social housing, and providing direct funding to seniors and those with disabilities who would like to arrange their own care.

RETAINING, RECRUITING AND TRAINING HEALTH PROVIDERS

Supporting, attracting and keeping skilled personnel is the single largest challenge for Saskatchewan's health care system. This plan recognizes the importance of promoting caring, respectful workplaces, where health providers can fully use their skills and training.

The formation of primary health care teams across the province will offer improved services for patients and a supportive practice environment that will be attractive to many providers.

A comprehensive health human resource strategy will provide $3 million in new funding to train more health providers and to offer return-service bursaries for students studying in selected health programs. The strategy will include expanded continuing education and professional development for health providers, staff and managers to upgrade their skills. It will also support initiatives to retain, recruit and train Aboriginal people working in the health sector. Finally, the health human resource strategy will provide additional support for initiatives to develop quality health workplaces.

Health Training and Research

The College of Medicine, with a renewed mandate, and the College of Nursing will be two of the partners in a new Academic Health Sciences Network. The network will have a presence in all health regions, through practical training and mentorship programs.

Health research is important to health care as well as to economic development in Saskatchewan. Medical specialists are attracted to locations with a strong research environment. The universities and some specialists have expressed the need for further research funding that would help attract additional research dollars from other sources. Research into the health of our population and the effectiveness of health programs is also important. Our plan will increase support for health research by 40 per cent in the 2002-03 budget by adding $2 million to the $5 million invested this year, with further increases to follow.

A COMMITMENT TO QUALITY, EFFICIENCY AND ACCOUNTABILITY

Health care is a top priority for Saskatchewan people and it receives the largest share of provincial government spending. This year, the province will spend over $2.2 billion on health – nearly 40 per cent of provincial program spending.

We know how and where the money is being spent. But we need better information about whether health dollars are going toward the programs and services that provide the greatest health benefit.

By tracking and reporting on the quality of our health care system, we can determine if services are overused, underused or misused, and shift health spending to those services that are the most effective.

For this reason, a Quality Council will be established, with a mandate to develop evidence-based standards in health care delivery, evaluate new technologies and treatments, and report to the public on issues of health care quality.

Regional Health Authorities

The innovations in health services contained in this plan will require strong leadership and effective planning across the province. To achieve these goals, the current 32 health districts will be replaced by 12 Regional Health Authorities. The Athabasca Health Authority will continue as a partnership involving First Nations and the provincial and federal governments. The new health regions will work closely with the provincial government in planning health care delivery.

The regions will be governed by 12-member boards appointed by the Minister of Health. Board members of the Regional Health Authorities will be selected from community leaders and individuals with the knowledge and commitment to lead the health system. At least half of the original members will be appointed from the current health district board membership. Community Advisory Networks will be established to provide additional guidance to Regional Health Authority boards.

A new budgeting process will be implemented, so Regional Health Authorities receive early budget targets and have their budgets approved at the outset of the fiscal year. Multi-year funding targets will be provided to allow for better long-term planning.

Health Care Costs

While our plan will help to contain the rate of growth, it will not change the fundamental fact that health care costs grow year after year. Paying for the health care system we want and need will continue to be a challenge in the future.

Saskatchewan residents agree that accessible quality health care is the top priority of government. Our commitment to the ideals of publicly funded Medicare continues. Not only is publicly funded health care proven to be the most cost-effective model, it is also the best way to make health care equally available to all.

Our health plan will set Saskatchewan on the road to a more efficient, more affordable health care system. However, the fundamental trends that cause health care costs to grow year after year remain. Paying for the health care system we want and need will continue to be a challenge for the future. All provincial governments have concerns about sources of health care funding. Right now, we are spending more on health care in Saskatchewan than the province collects in personal income taxes and the provincial sales tax. We must work with all our health sector partners to implement cost-effective approaches to health care delivery. We must also work with the federal government to ensure that there is adequate funding to protect Medicare for all Canadians.

CONCLUSION

Taken together, these measures will address the immediate needs of our health system, while providing the long-term direction that will guide future decisions and investments in health care.

This health plan offers a better way of delivering everyday primary health care services; it establishes clear expectations around the delivery of hospital services; it provides a more effective way of delivering emergency medical services; and it offers additional choices for seniors and disabled people to help them remain independent in the community. With these changes, Saskatchewan people will have access to a full range of health care services that they can depend upon for all of their health needs.

Changes in the health delivery system will be complemented by initiatives to retain and recruit health care providers and a health governance system that is more effective, more efficient, and more accountable for health dollars. While this health plan includes specific investments in some areas to allow planning to begin immediately, most decisions around health care spending will be made through the budget planning process.

This document provides a plan of action and a long-term direction for changes in health care, but it does not specifically address all programs and priorities in the health sector. For example, this health plan does not prescribe changes in key areas such as the Provincial Laboratory, Health Registration and Vital Statistics, the Saskatchewan Drug Plan, or the Saskatchewan Aids to Independent Living Program. However, these programs will continue to play an essential role in the delivery of health services in our province.

Our commitment to the people of Saskatchewan is an accessible, quality health care system that is sustainable for the future. *The Action Plan for Saskatchewan Health Care* provides a fair and balanced modernization of our health care system, building on our existing strengths and setting a better course for the future.

The Plan For Primary Health Care

Primary health care services are usually the first point of contact people have with the health care system. They are also the most frequent point of contact, so it is essential for these services to be organized and delivered in the most effective way possible.

Our health plan will co-ordinate and expand primary health care services, and improve patient care. We will begin by organizing doctors, nurses, therapists and other front-line providers into teams so that patients have better access to the most suitable health care provider. Patient care will be better co-ordinated and more personal, as providers work together to meet specific needs. These teams will diagnose and treat illness, but will also focus on preventing health problems and managing existing ones so they do not become more serious.

The primary health care teams will be part of primary health care networks in the 12 new Regional Health Authorities. Each network will offer a full range of everyday health services, and will be supported by a 24-hour telephone line that Saskatchewan residents can call for convenient, immediate health information and advice.

A PRIMARY HEALTH CARE PRIMER

Across Canada and around the world, people who work in the health system are talking about a better way of delivering basic, front-line health care. That better way is primary health care. This term does not mean much to the average person, but we have all received primary health care at various times in our lives.

Primary health care covers everything from the diagnosis of a common illness to the treatment of minor injuries to the management of ongoing problems such as asthma, diabetes, high blood pressure, or anxiety.

"If we compare health services to groceries, primary health care is the bread, eggs and milk that can be found in every community's corner store. The more specialized health services would be similar to fresh mussels that are usually only found in the specialty shops or large super stores in the larger communities."

Dr. Martin Vogel, Shaunavon family physician

Primary health care includes the doctor who sees patients when a health concern arises, the public health nurse who visits schools and new moms, the nutritionist who counsels people with diabetes, and the home care worker who provides personal care, such as bathing, to help seniors remain in their homes. It also includes information received at a clinic or in the mail about how to identify the signs of heart attack, how to identify signs of depression, or how to successfully quit smoking. All of these activities are aimed at helping people stay healthy, and adding quality years to their lives.

These basic, everyday services represent the vast majority of public contacts with the health system, so it is essential that they be organized and delivered in the most effective way possible.

Primary health care is not new. But there are new ideas on how to redesign it to improve patient care.

"A major reorganization of our primary health services is fundamental to the sustainability and improvement of 'everyday' health services for everyone."

Saskatchewan Association of Health Organizations

MAKING BETTER USE OF OUR HEALTH PROVIDERS

There are thousands of health care providers – from many health professions – involved in the delivery of primary health care in Saskatchewan. However, under the current system, they do not always work as a cohesive team, and not all of them are being used as effectively as they could be.

Networks and teams engaged in the delivery of primary health services could include:

- family physicians
- medical health officers
- primary care nurses
- public health nurses
- nutritionists/dietitians
- physiotherapists
- social workers
- dentists
- chiropodists
- chiropractors
- home care nurses and workers
- mental health nurses and workers
- addictions workers
- psychologists
- optometrists
- pharmacists
- paramedics/emergency medical technicians
- exercise and fitness specialists

Members of different health professions often work in isolation, with doctors, pharmacists, therapists, mental health workers and other primary health care providers practicing in different locations. Their busy workloads can make it difficult for them to consult one another. This means they cannot always work together to ensure patient care is shared among all of the appropriate providers.

There are examples in the province where teamwork is taking place and working to meet the needs of the community. Specific instances can be found in community clinics, health centres, primary health service sites, and some physician practices. This health plan builds on our best teamwork practices to ensure all Saskatchewan residents have access to the best care possible.

Seventy-four health centres in the province provide a wide range of health services to meet individual, family and community health needs close to home. The services offered in health centres vary from community to community, depending on the needs of local residents. Health centres will continue to play an important role in our health system, as health providers in these locations become key members of primary health care teams.

At a time when we are experiencing shortages in a number of health professions, it is essential that we use the knowledge and skills of all health providers to the greatest extent possible. There are many patient needs that can only be met by a physician. However, for some routine illnesses and injuries, a nurse with advanced

"Having a doctor do work that a nurse practitioner or nurse could do is like calling an electrician to change a light bulb or a licensed mechanic out of the garage to fill your tank and check the oil and tire pressure. Would they do a good job? They would do an excellent job! But would it be good use of their time, training and expertise? It would not! It would constitute an expensive and inefficient use of scarce resources, both of money and the expertise of very talented people."

The Health of Canadians, Volume IV, The Senate Standing Committee on Social Affairs, Science and Technology

training could provide the necessary care, or a visit to a doctor could be followed up with visits to a nutritionist, pharmacist or mental health counsellor. Sharing patient care with other health professionals will allow doctors to spend more time with those patients who require the special skills of a physician. Another example: more than 100,000 people received mental health services from their family physician last year. Sharing patient care with other mental health workers would ensure that patients who require mental health care have access to a broader network of appropriate providers.

With the help of computer technology, primary health care teams can monitor patients with chronic diseases, such as diabetes, asthma and hypertension, to ensure they receive regular follow-up care. This technology, which is currently being used in several primary health care pilot projects, allows health care providers to be proactive in recalling clients for appointments and tests that play an important role in maintaining good health. For example, primary health care teams can identify their patients with diabetes and ensure they receive regular eye examinations, blood-glucose, blood pressure and cholesterol tests, to assist in the early detection of diabetes-related health problems. This technology also supports screening programs for the early detection of disease.

When health providers are working together effectively, the result is better patient care. It means the sharing of the same information, so patients do not have to recite their medical history each time they visit a different provider. It means diagnostic tests are co-ordinated, so they do not have to be repeated. Most importantly, it means better access to a qualified health professional who has more time to offer the personalized care that patients require.

THE BATTLEFORDS FAMILY HEALTH CENTRE

At the Battlefords Family Health Centre, primary care nurses work alongside family physicians to provide health services that promote good health through early intervention, patient education and case management for people with chronic conditions.

The centre has a child development program that provides support for families with children with learning disabilities, particularly children affected by Fetal Alcohol Syndrome or substance abuse. Team members include a speech language pathologist and an early childhood psychologist from the Battlefords Health District, a pediatrician from the Children's Kinsmen Centre in Saskatoon, health liaison workers and community nurses from the Battlefords Tribal Council, and a clinic co-ordinator funded through Social Services and the Associated Entities Fund.

The centre also established a sexual awareness clinic that provides counselling, support and treatment for patients with sexually transmitted diseases, as well as education and counselling in the area of sexual health and wellness.

PROGRESS THROUGH PILOT PROJECTS

Over the past four years, Saskatchewan Health has supported the development of 20 demonstration projects in communities across the province, where teams of

primary health care providers work together to address the health needs of local residents. In addition to diagnosing and treating common ailments, these teams offer screening and monitoring programs to prevent and manage chronic diseases. Some of the programs are specifically designed to reach out to high-risk individuals and families who are sometimes overlooked by the traditional methods of health delivery.

The 20 demonstration projects serve over 80,000 people and offer the services of 44 doctors, 21 primary care nurses with advanced clinical training, and a wide range of other providers. The doctors are paid by salary or contract, instead of receiving a "fee for service" every time they see a patient. This allows the doctors to spend more time with patients who have complex health problems, providing advice and education to help them maintain and improve their health.

Recent legislative changes mean primary care nurses will be licensed to practise in an advanced clinical role, allowing them to work in collaboration with physicians and other health professionals.

The Action Plan

Our health plan will make primary health care a top priority in the days and months ahead.

ESTABLISH PRIMARY HEALTH CARE NETWORKS

- We will establish primary health care networks in all 12 Regional Health Authorities, offering a full range of primary health care services. The networks will be developed in stages, and the pace may vary in different locations. After four years, primary health care teams will serve 25 per cent of Saskatchewan families. Within 10 years, the entire Saskatchewan population will have access to primary health care teams. Core services will include:
  - primary medical care
  - emergency medical services
  - mental health
  - addictions counselling
  - public health
  - special care homes, respite care, adult day care
  - home care
  - end-of-life (palliative) care
  - laboratory and x-ray services
  - support for informal caregivers
  - therapy services (e.g. physio, occupational, speech and language)

- Each regional network will consist of one or more teams, with each team serving several communities. The team members would typically include a group of physicians, primary care nurses, pharmacists, social workers and mental health workers. Other team members, such as dietitians, speech and language pathologists and psychologists, would belong to more than one team. Once implemented, our goal is that all communities will have access to primary health care within 30 minutes.

- Family doctors will join the primary health care teams on a voluntary basis. Doctors practising in the primary health care teams will be paid on contract or salary, rather than a predominantly fee-for-service method. Saskatchewan Health will work with the Saskatchewan Medical Association, and Regional Health Authorities, to develop a range of model alternate payment contracts.

IMPROVE HEALTH INFORMATION SYSTEMS

- Better computer information systems will give health care providers the information they need to co-ordinate patient care and appointments, reduce the risk of drug interactions, and avoid duplicate diagnostic testing.

- High speed internet service through CommunityNet will give health care providers in rural areas a faster, easier way to consult with their counterparts in other centres. CommunityNet will advance the work of the Saskatchewan Health Information Network in developing a province-wide Telehealth Network.

ESTABLISH A 24-HOUR HEALTH ADVICE LINE

- We will establish a toll-free 24-hour telephone advice line to support the primary health care networks. The toll-free phone line will be staffed by nurses who will assess patient symptoms and advise callers where to go for help. In less serious cases, the nurses will provide advice on how callers can care for themselves. The advice line will begin operation within a year.

TELEPHONE ADVICE LINES WORK

- **There are province-wide telephone advice lines in British Columbia, Ontario, Quebec, and New Brunswick, and limited services in Alberta.**

- **Telephone advice lines have been well received by the public, with user satisfaction generally around 90 per cent.**

- **Studies have consistently shown that telephone advice lines result in more appropriate use of emergency departments. Fifteen to 20 per cent of callers are directed to an emergency department, 25 to 40 per cent are directed to a physician's office, and 45 to 60 per cent of calls lead to self care.**

- **In a telephone advice line pilot study completed in New Brunswick, emergency room visits for common accidents and illnesses, such as sprains, strains, cold and flu, were reduced by 22 to 45 per cent.**

- **Telephone advice lines save patients' time and money. They can help eliminate unnecessary trips to a physician's office or an emergency room, and prevent unnecessary ambulance trips.**

WORKING WITH COMMUNITIES

Regional primary health care networks will be developed in stages, and the pace may vary from region to region and community to community. Comprehensive health networks cannot be created overnight. More primary care nurses with advanced training will be required, and attracting physicians from private practices will also happen gradually.

The networks will be developed in consultation with health providers, who will have valuable insights into how the primary care teams should be assembled and how services should be delivered. There will also be strong community involvement. Regional Health Authorities will bring community members into the planning process early on, to ensure their wisdom is reflected in the programs and services provided by the primary care teams.

Depending on the needs of the community, special emphasis may be given to programs aimed at preventing

and encouraging better management of conditions such as diabetes, lung disease or heart disease.

Within four years, all Regional Health Authorities will have planned and begun implementation of their primary health care networks. They will have developed the tools – including better information technology to handle patient records – to support the full development of these networks. After four years, it is expected that primary health care teams will serve 25 per cent of Saskatchewan families. Within 10 years, the entire Saskatchewan population will have access to primary health care teams.

BETTER HEALTH, BETTER CARE

Better primary care will benefit everyone in Saskatchewan. For patients, province-wide networks of primary health care teams will mean access to the appropriate health professional for a specific need, co-ordination of out-of-town tests and appointments to help eliminate excess travel time, and earlier detection and management of illness to prevent more serious health problems, and expensive treatments, down the road.

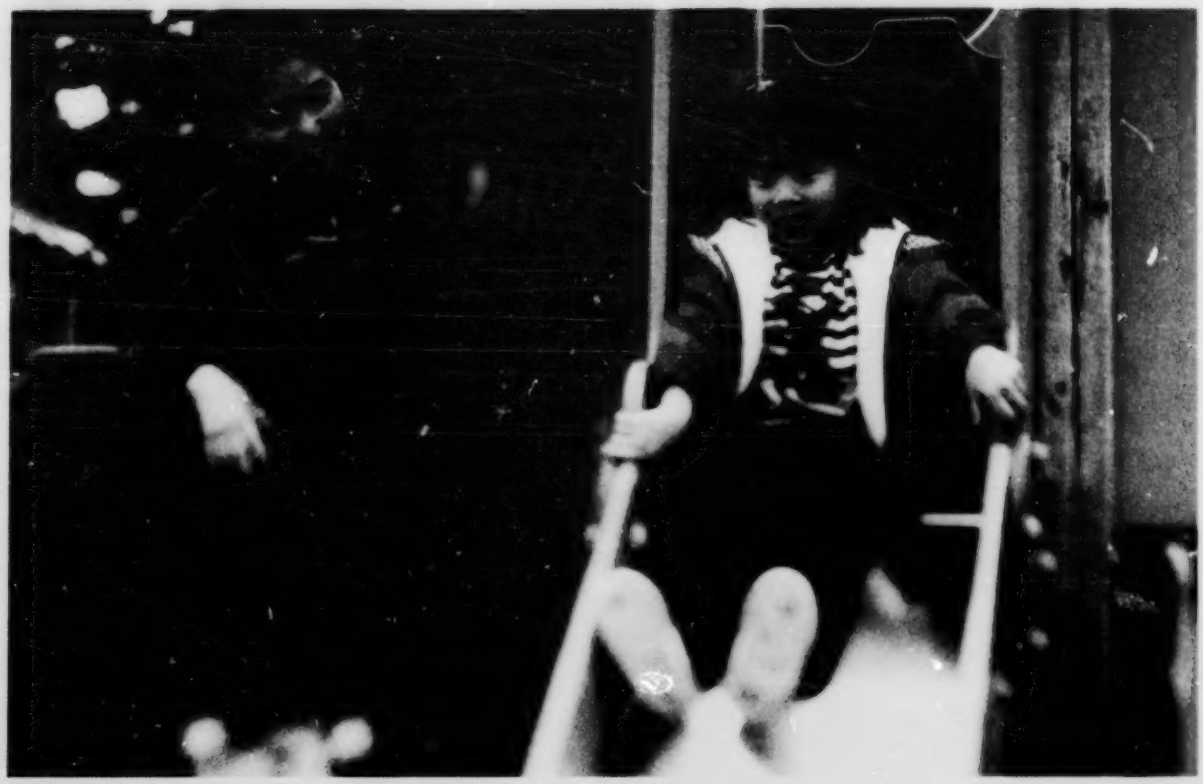
For health care professionals, the development of primary health care teams will mean a better work environment, where providers enjoy the collegial nature of practising as part of a team. Team members will use their time more effectively and have the satisfaction of using the full range of their skills.

For physicians, joining a primary health care team will provide an improved professional environment that supports clinical practice and allows for a better quality of life. The pace is less hectic, as responsibilities are shared with other providers. Regular office hours with shared on-call coverage responsibilities allow for a better balance between work and family.

For all Saskatchewan residents, there will be improved, overall health through a primary care focus on illness and injury prevention, along with the diagnosis and treatment of health problems. With the advent of a toll-free 24-hour health line, Saskatchewan people will have the comfort and security of knowing that expert advice is only a phone call away.

"The SMA supports the (Fyke) Commission's observation that the time has come to develop a comprehensive strategy for the future of primary care delivery, including a clear definition of provider roles and responsibilities, coupled with a range of payment options."

Saskatchewan Medical Association submission to the Standing Committee on Health Care



The Plan To Promote Healthy Communities

What is the secret to good health? A reliable health care system that can diagnose and treat illness is certainly important. But it takes much more than that. Having an excellent health care system is no guarantee of a healthy community.

The most important influences on the health of people are things like income, education, diet, housing, and support from family and friends. By addressing these underlying "determinants" of health, we can improve the health outlook for individuals and entire communities. By helping people stay healthier, longer, we can also reduce some of the strain on our health care system, as fewer people require expensive treatments and medications.

Our health plan will continue support for a variety of health promotion initiatives, and for policies and programs that improve the quality of life for Saskatchewan people. In the coming year, we will work with Regional Health Authorities, health groups and service agencies on health promotion activities throughout the province. Province-wide health promotion and disease prevention initiatives will be based on a common provincial strategy, with Regional Health Authorities offering local programs based on the needs of their communities.

AN OUNCE OF PREVENTION

Health is about creating communities where it is easy for people to live, work and play in healthy ways. There are many things we can do to prevent or lessen health problems, instead of just treating them after the fact. We can, for instance:

- ensure expectant mothers understand the importance of eating the right foods and avoiding tobacco and alcohol;
- promote physical activity as a means of preventing heart disease, diabetes and other health problems;
- provide low-income families with access to nutritious food through community gardens and good food box programs; and
- pass laws that make it illegal to sell cigarettes to youth.

Our understanding of what keeps people healthy has grown. At one time, the health system focused its attention on treating individuals when they became sick. However, we came to understand that what we eat, how active we are, and whether we use tobacco and alcohol affect how healthy we are. This *lifestyle approach* helps individuals reduce their health risks by changing their behaviour.

Today we recognize that the picture is even bigger. The *population or community health approach* reveals that the health of the community and province is influenced by many factors beyond health care and individual behaviour. Today we understand that having community and family supports, a good job, and a healthy environment have a significant effect on our health. People are much more likely to be healthy if they live in communities where it is "easy" to be healthy.

The Commission on Medicare recognized that "avoiding disease and injury is preferable to even the most magical cure." In fact, every major report on Canada's health system since the mid-1970s has identified the need to shift more emphasis to health promotion and disease prevention in order to improve the health of Canadians.

> *"In general, people with more education are healthier than people with less. People with secure, well-paying jobs are healthier than those without them. Children born to middle-class families are healthier than children born to the poor. It is not simply an issue of any one factor, but a combination of these factors that reduces our risk of disease or increases our chances at good health."*
>
> **Commission on Medicare Report**

SILENT SUCCESS

When you receive medical attention for a health problem, the results are obvious. You come away with a prescription in hand, a cast on your foot, or a referral for follow-up tests or appointments. You see the health system at work and notice a difference in your health.

The benefits of health promotion and disease prevention initiatives are not immediately apparent. They occur over an extended period of time and they can be difficult to measure. Healthy people do not spend much time thinking

about the factors that have contributed to their well-being. Success is marked by a non-event, which makes health promotion a "hard sell" when it is forced to compete with the urgent and emotional needs of the acute care system.

The challenge is to achieve a balance of effective treatment services and population health promotion. The truth is they are both important. They cannot and should not compete with one another. Treatment and population health promotion are both needed to make sure that Saskatchewan people are the healthiest they can be.

POPULATION HEALTH PROMOTION AT WORK

Building better communities takes time and it takes the talents of many people from all walks of life. Health promotion programs often involve participants from outside the health sector, including education, social services, business, charitable and religious organizations.

Government departments, health districts and health providers, Aboriginal groups, and community organizations have worked together to create promising health promotion initiatives across the province. Here are just a few examples:

- Through the **Building Independence** initiative, the province supplements wages and maintenance payments for low income families, and also provides them with extended health benefits. This initiative helps reduce child poverty by enabling parents of low income families to work their way off welfare and into the workforce.

- **Diabetes prevention pilot projects** have been established in communities across the province. Diabetes is a growing problem in Saskatchewan and across Canada, as our population ages and becomes less active and more obese. Each year in Saskatchewan, 3,200 people develop this chronic disease. Studies show that the risk of developing type-2 diabetes can be reduced by significantly increasing physical activity and eating healthy foods. Diabetes prevention projects located in urban, rural and northern communities have developed walking trails, worked with schools on healthy nutrition and physical activity policies, expanded good food box programs, and formed partnerships with area media to broadcast information in Cree and Dene, as well as English.

- The government is working with communities to double the number of **community schools** in the province. Community schools encourage parent and community involvement in the school, to help students learn and grow. By expanding the traditional role of the school, they provide extra support to students and families to help them overcome obstacles. Community schools offer pre-kindergarten, nutrition and babysitting programs, cultural activities, and classes for parents, such as resume writing, and show that success in school is linked to success in life.

- Saskatchewan has made significant investments in **early childhood programs**, particularly since the introduction of the Child Action Plan in 1993. A recent initiative is the KidsFirst program, which was developed with financial support from the federal government. KidsFirst provides intensive early childhood supports for vulnerable families with children up to the age of five. The program is targeted to communities where families face challenges such as poverty, low education levels, dependence on social assistance or single parenthood. Eligible families receive home visits and services such as expanded child care and early learning programs.

- There are several initiatives in place to reduce the number of infant deaths in our province. Infant mortality has been linked to a number of factors, including premature delivery, birth defects, low birth

"Ask people what makes them and their community healthy and they'll tell you – a good job, a decent education, a clean and safe environment, proper housing, less poverty, a sense of community."

Saskatchewan Population Health and Evaluation Research Unit
(University of Regina/University of Saskatchewan) submission to the Standing Committee on Health Care

weight, and maternal factors such as poor nutrition, smoking, substance abuse, infection and disease during pregnancy, and low socio-economic status. **Programs to support healthy mothers and babies** include prenatal nutrition advice, breast feeding promotion and education, postnatal assistance, and childhood immunizations against communicable diseases.

- The province is working with schools, municipalities and recreation groups to encourage Saskatchewan people to be more physically active. A new fitness strategy entitled **A Physically Active Saskatchewan: A Strategy To Get Saskatchewan People In Motion** is designed to address increasing levels of physical inactivity.

- Programs to **reduce workplace and farming accidents, automobile and boating accidents, and recreation and sporting accidents** are preventing injuries and accidental deaths.

- The River Bank Development Corp. in Prince Albert was developed because low income people needed affordable housing and also wanted to own their own homes. With the assistance of governments, community leaders and private businesses, **community-based housing co-operatives** were established. To date, 39 low income families have their own homes and a fourth housing co-operative is currently being developed. Ten of the co-op residents are making a living wage working on the projects.

The Action Plan

Our health plan supports an increased focus on population health promotion throughout the province.

DEVELOP A PROVINCIAL POPULATION HEALTH PROMOTION STRATEGY

- Provincially, we will work with Regional Health Authorities, health groups, the business community, municipal governments, human services agencies, and other partners in education and social services on a strategy to guide health promotion activities across Saskatchewan. This strategy will identify the top priority areas for health promotion and disease prevention initiatives, and will be guided by research that looks at the needs of Saskatchewan people and communities. Future investments in health promotion activities will be used to support the province-wide strategy.

- Locally, Regional Health Authorities, using the provincial priorities as a foundation, will develop action plans based on the needs of their respective communities. Health authorities will be expected to

report annually on the health promotion and disease prevention initiatives they are pursuing.

Moving from 32 districts to 12 Regional Health Authorities will allow for better co-ordination of health promotion activities across the province. These larger bodies will have a greater capacity to plan and implement health promotion activities throughout their regions.

IMPLEMENT BETTER MEASUREMENT AND PUBLIC REPORTING OF HEALTH STATUS

How healthy are Saskatchewan people? Like all provinces, Saskatchewan measures health status by collecting statistics on "health indicators" such as life expectancy, infant mortality and the incidence of various diseases. It comes as no surprise that we are living longer, healthier lives. Still, we need to know what is causing this improved health status and what stands in the way of better health.

- We will be collaborating with researchers from the University of Regina and the University of Saskatchewan on a major survey of the health status of Saskatchewan people, in order to answer these questions. Researchers will examine the physical, mental and emotional health of Saskatchewan residents, as well as major influences over health, including income, education, and health behaviours such as smoking and exercise.

This study will give us new insight into the health of Saskatchewan people and establish baseline data for future reporting on the health of Saskatchewan people. With accurate information, we can measure the success of existing programs and services, and develop new strategies to build healthier communities.

OTHER HEALTH PLAN INITIATIVES

Primary Health Care Teams

- The formation of primary health care teams involves a shift to team-based delivery of everyday health services. It also involves a shift toward a more pro-active approach to the prevention of illness and injury. Working in teams, health providers, including primary care nurses, family doctors, public health nurses, nutritionists, and social workers, will look at the broader health needs of individuals and families. They will provide advice on ways to prevent diseases such as diabetes, heart and lung disease, or advice to new mothers on how to increase the likelihood of a healthy pregnancy and a healthy baby.

A Northern Health Strategy

- Saskatchewan will support the development of a Northern Health Strategy that rests on the principles of health promotion and disease prevention, and recognizes the importance of addressing the extraordinary circumstances that have led to higher rates of accidents and illness in the North.

BETTER HEALTH THROUGH PROMOTION

Treating illness and promoting good health are essential features of a quality health care system. They should be treated as compatible – not competing – activities along the full continuum of health services. Saskatchewan people recognize the importance of promoting healthy communities and are developing new ways of achieving this goal.

Population health promotion will be a key strategy in improving the health of Saskatchewan people and supporting the long-term sustainability of our public health system.

The Plan For Northern and Aboriginal Health

Northern and Aboriginal communities have their own issues and concerns when it comes to health care. They also have a unique perspective on how to bring better health care to their people.

Leaders from the three northern health districts and the Northern Inter-Tribal Health Authority are working on a Northern Health Strategy that is built on principles developed by and for northern residents. Our government supports the development of a Northern Health Strategy and we will continue to work with northern residents and the Government of Canada toward its completion.

Beyond supporting the Northern Health Strategy, our health plan establishes two Regional Health Authorities in the North, in addition to the Athabasca Health Authority. The plan ensures a broad range of health services in northern communities, with links to specialized services across the province. Our health plan also includes initiatives that consider both on- and off-reserve health care, that ensure greater Aboriginal representation in the health workforce, and that look for opportunities to manage and deliver health services in a more co-ordinated and effective manner.

CHALLENGES IN THE NORTH

Northern Saskatchewan is experiencing a baby boom, a fact that weighs heavily on decisions about the delivery of health, education and social services.

Forty per cent of our northern population is under the age of 15. This means services must be geared toward children and young families – from prenatal services to child care programs to early learning programs.

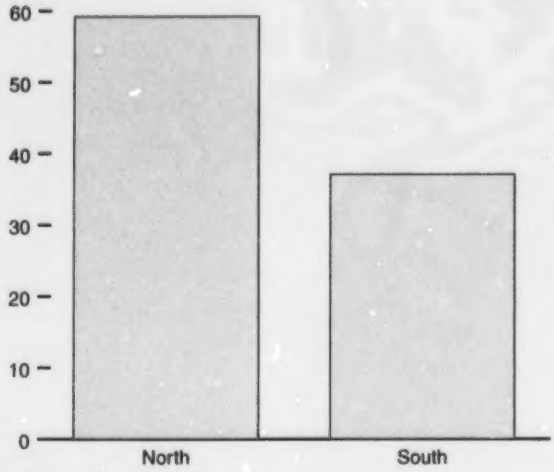
According to a study by the Health Services Utilization Research Commission (HSURC), the populations of the Mamawetan Churchill River Health District, Keewatin Yatthe Health District and Athabasca Health Authority will grow by 49, 24 and nine per cent, respectively, over the next 15 years – making the North the fastest growing area of the province. Health services will need to expand and adapt in order to meet the needs of this growing population.

There are other serious challenges in northern health care, from the complexity of delivering services to a small population spread across half of Saskatchewan's land mass to high rates of disease and widespread poverty and unemployment.

Northern Saskatchewan offers an example of how factors such as income, education, diet, housing and early childhood development exert a tremendous influence over long-term health status. High unemployment rates in the North mean income levels are substantially lower than the rest of Saskatchewan. Some families do not have adequate nutrition. It is no coincidence that rates of diabetes, heart disease, lung disease and communicable disease are higher in the North than most parts of the province.

DIABETES IN SASKATCHEWAN

Diabetes cases per 1,000 population, 1996



Source: Saskatchewan Health

NORTHERN HEALTH SERVICES

Living in small communities far from the nearest hospital, doctor or nursing home, many northerners have come to rely on primary health care clinics, public health offices, home care services and first responders to meet their immediate health needs. Health education and promotion play an essential role in the delivery of northern health care.

Hospital services are available in the larger centres of La Ronge, Ile a la Crosse, and La Loche, while residents in the Sandy Bay–Creighton area use the hospital across the Manitoba border, in Flin Flon. Many northern residents also receive care in Meadow Lake or Prince Albert. A new hospital at Stony Rapids is under construction and will be open in 2003 to replace the Uranium City Hospital.

In the past, northerners travelled for hours by car or by aircraft to see specialists in Prince Albert, Saskatoon and Regina. Today, residents in remote locations can attend appointments without leaving their communities through video links for specialists in larger centres. Telehealth Saskatchewan sites in Pinehouse, La Ronge, Ile a la

Crosse, and Beauval link northern residents to medical specialists, and are also used for diabetic counselling, acquired brain injury consultations and continuing health education. Doctors can see and talk to patients, read health records and view x-ray results, allowing them to diagnose and treat patients from a distant location.

The 24-hour telephone advice line will provide northern residents with immediate access to health advice and information, no matter where they live, what time of day it is, or what the weather conditions are like. The toll-free phone line will be staffed by nurses who can provide advice on the most appropriate way to handle health problems – either in the home or through the services of another health provider.

A NORTHERN HEALTH STRATEGY

Over the past year, leaders from the three northern health districts and the Northern Inter-Tribal Health Authority, representing northern Tribal Councils and First Nations, began discussing a new strategy to meet the health needs of northern people.

The basis for a Northern Health Strategy is the concept of holistic primary health care that considers the physical, mental, emotional and spiritual health of individuals, families and communities. This work identifies health promotion and illness prevention as cornerstones of the strategy, and considers the North's unique languages, and the cultural and socio-economic situation.

FIRST NATIONS HEALTH SERVICES

Responsibility for the delivery of health services to First Nations people is divided among the Government of Canada, the Government of Saskatchewan, individual bands and Tribal Councils, and local health districts. This complex administrative arrangement can make it difficult to co-ordinate the delivery of health services to First Nations people.

There is a need to manage health services and health spending in a more cohesive manner, in order to better meet the needs of First Nations people. A number of suggestions have come forward on how to achieve this.

The Commission on Medicare called for a structured dialogue involving representatives of First Nations people, and the federal and provincial governments. The proponents of the Northern Health Strategy have called for the development of service partnerships, based on

A NORTHERN HEALTH STRATEGY MUST...

- be holistic;
- place individuals within the appropriate family and community context;
- recognize the North's unique historic, geographic, language, cultural and demographic situation;
- emphasize prevention and not just treatment;
- recognize and respect the complex jurisdictional issues in the North (First Nations, Metis, health districts, federal and provincial governments); and
- recognize that the health of northern people requires co-operation and support from departments and agencies that don't view themselves as delivering health services.

Northern Health Strategy submission to the Standing Committee on Health

"Partnerships between health districts and First Nations health services are vital, especially where the reserves are adjacent to non-First Nations communities. The respective populations are too small to permit a duplication of services, and often too small to provide an adequate range of primary health services."

Saskatchewan Association of Health Organizations submission to the Commission on Medicare

shared goals, in order to "create a system that maximizes northern health resources."

Recently, Health Canada provided additional funding to the Northern Inter-Tribal Health Authority to assume responsibility for a wider range of services, such as northern public health services delivered to First Nations communities. This is a welcome development which offers the new northern Regional Health Authorities and the Northern Inter-Tribal Health Authority an opportunity to discuss potential areas for collaboration in the delivery of health services, particularly in the area of primary health care services.

OFF-RESERVE HEALTH CARE

First Nations people living off-reserve have access to a broad range of health services in urban communities, but these services do not always reflect First Nations customs, values, languages and traditional healing practices. Efforts are being made to remove these barriers in several communities, where primary health care clinics have been established with the involvement of First Nations people.

These primary health care clinics strive to prevent disease and promote individual, family and community health, and offer co-ordination between the services offered to First Nations people living both on- and off-reserve.

As primary health care services are expanded throughout the province, priority for implementation will be given to those areas with the greatest identifiable need, including urban, rural and northern areas with high-risk populations.

BRIDGING THE GAP

The White Buffalo Youth Lodge in Saskatoon is a multi-purpose health and recreational facility designed to meet the needs of children and youth, many of whom are First Nations, in the core areas of Saskatoon. The lodge was developed through a partnership between the Saskatoon Health District, Saskatoon Tribal Council, City of Saskatoon, and Saskatoon Metis Urban Council.

The lodge offers recreational and school programs, as well as primary health care services, including medical, dental, nursing, public health and counselling services. The lodge also offers traditional cultural programs with storytelling, drumming and singing, and has an Elder in Residence.

The Four Directions Community Health Centre in north central Regina offers a range of programs especially targeted to the Aboriginal community. The centre provides health services through a team of professionals that includes public health nurses, a primary care nurse, a community development co-ordinator, community mental health workers, an addictions counsellor, and a nutritionist.

Family physicians provide visiting medical services and support to the centre's primary care nurse. The centre also has a community advisory circle to ensure the community is part of the planning and delivery of services and programs.

METIS PEOPLE'S HEALTH SERVICES

Health services for Metis people are not funded and delivered in the same way as services for First Nations people living on-reserve. For example, the Metis in Saskatchewan do not have the same relationship with the federal government and do not have direct control of health services delivery. Yet, Metis people living in both urban and rural areas will benefit from a better model for delivering primary care.

As appropriate, Metis leaders will continue to be appointed to the boards of the new Regional Health Authorities where they can speak to the needs of their communities. We will continue to implement the broad-based Metis and Off-Reserve First Nations Strategy, which is designed to improve the social and economic situation of Metis and First Nations people living off-reserve, which in turn will have a major effect on their overall health.

A REPRESENTATIVE WORKFORCE

One way to make the health system more sensitive to First Nations and Metis culture is to ensure Aboriginal people are represented in health workplaces throughout the province.

Efforts to increase Aboriginal participation in the health workforce are underway on several fronts. One such initiative is a program offered by the Saskatchewan Indian Federated College that helps Aboriginal students to upgrade their science, math and English skills in preparation for post-secondary study in nursing or other health-related programs.

Our government is also working with First Nations and Metis organizations on the development of a nursing degree program for northern Saskatchewan.

"In order for a revamped health system to meet the needs of the First Nations people both on- and off-reserve, the system must be culturally sensitive to the physical, mental, emotional and spiritual needs of First Nations and work with First Nations to integrate values into the contemporary health system."

File Hills Qu'Appelle Tribal Council submission to the Standing Committee on Health Care

Many of the province's health districts have set guidelines for the hiring and training of Aboriginal health workers. To ensure non-Aboriginal employees are familiar with and respectful of First Nations and Metis culture, many districts also offer cultural awareness training to staff members.

The Action Plan

Our health plan includes a commitment to improving health services in northern communities, and we will work with northern and Aboriginal leaders to find solutions to the unique challenges they face.

SUPPORT A NORTHERN HEALTH STRATEGY

- We support the development of a Northern Health Strategy. Representatives from Saskatchewan Health, the northern districts and the Northern Inter-Tribal Health Authority met in the spring of 2001 and agreed that the next step will be a Memorandum of Understanding that reflects the commitments of the various partners in the process. A working group will develop a plan to further define the Northern Health Strategy based on previously identified goals and objectives.

STRENGTHEN NORTHERN HEALTH SERVICES

- We will have two Regional Health Authorities in the North, along with the Athabasca Health Authority.

- Our health plan supports northern hospitals in La Ronge, Ile a la Crosse, La Loche and Stony Rapids, where the new Athabasca Health Facility is under construction. We also support the planning of a new hospital in Ile a la Crosse, to replace the existing facility.

STRENGTHEN ABORIGINAL HEALTH SERVICES

- The federal and provincial governments have begun negotiations that could see additional federal funding for primary health care for Metis and First Nations people living on- and off-reserve. This new funding would come from the Primary Health Transition Fund announced by Ottawa in September 2000.

- Primary health care services will be expanded in partnership with First Nations and Metis peoples to ensure the needs of Aboriginal communities are addressed as primary health care networks and teams are established. Areas with high-risk populations will be given priority in the development and implementation of expanded primary health care services.

- We will work with the College of Medicine and the College of Nursing and other health disciplines to establish strong partnerships with Aboriginal institutions and organizations, and to give greater priority to Aboriginal health issues, as part of a mandate that reflects priorities for health delivery in Saskatchewan.

- We will work with First Nations and Metis people, educational institutions and health employers to encourage greater Aboriginal participation inhealth workplaces.

The Plan For Better Emergency Medical Care

Saskatchewan people depend on quality emergency medical services. The health and safety of a loved one can often depend on a quick response from a well-trained health provider. So it is important that we offer consistent, high quality services across the province.

We will improve emergency response times, as resources allow, in areas where the need is greatest. We will also help emergency health providers improve their skills by offering more training and ensuring the availability of at least one emergency medical technician on the majority of calls.

Improving ambulance dispatch will mean better co-ordination and efficiency of our emergency services. We will also regulate ambulance fees and, ultimately, work toward a new fee structure that will ensure greater fairness for all Saskatchewan people.

VITAL SERVICES

In a province with a million people – scattered over urban, rural and northern areas – rapid, reliable emergency medical services (EMS) are vital to our health and well-being. As Ken Fyke noted in his Commission on Medicare report, "To feel safe and secure, citizens need to be able to count on emergency response services."

On the whole, Saskatchewan people can be proud of our emergency medical system. It responds to approximately 83,000 calls every year.

In the past year, our province devoted close to $30 million to emergency medical services, or about 1.3 per cent of the health budget. This covers grants to health districts to pay for road ambulance services and provincial programs such as the air ambulance service.

In spite of the excellent work being done by emergency health providers across the province, there is room for improvement.

In 2000, Saskatchewan Health received an independent report aimed at improving the EMS system. The report found that response times, training of staff, and ambulance fees vary widely across the province. It also found that the system is poorly co-ordinated, has some gaps in coverage, and does not ensure the most effective use of resources.

THE CURRENT EMS SYSTEM

The EMS system is more than just ambulances. It is the whole range of emergency care that patients receive right up to the hospital door. This includes road and air ambulance, first responders, police and fire departments, approximately 1,200 emergency medical technicians and paramedics, dispatch centres, and doctors and other professionals at hospital emergency wards.

There are currently 111 ambulance services providing care and transport to Saskatchewan people. Some are privately owned; some are owned by health districts.

CURRENT TRAINING LEVELS OF EMS PERSONNEL

Training Level	Number of Personnel
Emergency Medical Responder (EMR)	400
Emergency Medical Technician (EMT)-Basic	600
Emergency Medical Technician (EMT)-Advanced	100
Paramedic	100

Levels of training vary widely among EMS providers. Emergency medical responder is the entry level requiring 40 hours of training. Paramedic is the highest level requiring more than 1,800 hours of training. EMT-Basic (about 400 hours of training) is generally accepted in North America and Europe as the minimum training level to be provided by an ambulance service.

Currently, there are 26 centres that take phone calls and dispatch these services. Five of these are "wide-area dispatch centres" that are responsible for dispatching multiple ambulance services from different locations.

Saskatchewan Health provides funding to health districts to help pay for road ambulance services. Patients also pay a share of the cost. Fees and charges are set by each district, and they vary widely throughout the province.

WHAT IS AN AMBULANCE FEE?

There are a number of parts that make up a road ambulance fee (rates as of November 1, 2001):

- **a call "pick-up" fee (ranges from $130 to $250);**
- **a per kilometre travel rate (ranges from $1.10 km to $2.25/km);**
- **a per hour waiting time rate (if applicable); and**
- **a special health provider fee, if a health provider (e.g. nurse or respiratory therapist) is needed on the ambulance. This fee would be equal to the provider's hourly wage.**

For long trips, where patients are transferred from a rural area into a city, the fee can be hundreds of dollars. Rates are reduced or waived, however, for certain lower income groups. Seniors do not pay more than $250 for an ambulance trip.

The standard fee for an air ambulance trip is $350 plus the cost of road ambulance transfers to and from the airport. These flights are heavily subsidized by government. The cost of an average flight is about $3,400.

RECENT ENHANCEMENTS

During the past year, we have committed to improving wage and benefit parity among ambulance staff. This is expected to help our province attract and keep skilled health providers.

Also in the past year, we have announced plans to buy two new air ambulances. The two aircraft will replace our existing, ageing airplanes and ensure continued high-quality service during a time of increasing demand. The new aircraft have the ability to travel long distances at high speeds and are able to fly in a wide range of conditions. These are important factors in serving Saskatchewan people in rural and remote areas.

The first of our new air ambulances is now in service; the second will follow soon. This is a good start toward improving emergency services.

The Action Plan

Our health plan will improve Saskatchewan's emergency medical care through better training, co-ordination, efficiency, and fairness.

PROVIDE MORE TRAINING FOR EMS PROVIDERS

In an emergency, a quick response is important. Equally important are the skills of the EMS providers. This is because patients begin receiving care the minute help arrives.

- We will work toward a new standard of training. Beginning in 2002, our goal is to train 240 new or existing EMS providers up to the EMT-Basic level over a three-year period. This will help ensure that, on the majority of calls, there is at least one member of an ambulance crew trained and certified at the EMT-Basic level.

IMPROVE EMERGENCY RESPONSE TIMES

Given the geography of our province, ensuring a timely response in the most remote areas can be a challenge.

- As resources allow, we will target new funding to improve response times in areas where the need is the greatest, such as isolated areas where the nearest ambulance base is a long distance away.

IMPROVE DISPATCH OF AMBULANCE SERVICES

At present there are five wide-area dispatch centres: one in Regina that is health district owned and four owned by private ambulance services in Moose Jaw, Prince Albert, Saskatoon and Yorkton.

- We will improve co-ordination by having all calls for ambulance service in the province handled through the five wide-area dispatch centres. This does not mean we would change where ambulances are based in the province. It simply means that we would have a smaller number of centres handling dispatch for these ambulances. This will affect the 21 services that are currently doing their own dispatch.

- Handling all calls through five wide-area dispatch centres will ensure better use of ambulances to quickly respond to emergencies. For example, if ambulances from one service are tied up at a given time, a wide-area dispatcher could quickly deploy a unit from another nearby service, ensuring a person in need gets the quickest response possible. Over time, we will examine the potential advantages of even fewer call centres.

- Greater co-operation among ambulance services will also help avoid inefficiencies such as ambulances travelling back empty from a patient drop-off or sitting idle outside a hospital waiting for a patient (charging up to $100 per hour). A recent review showed patients were billed for 12,100 waiting time hours in 2000-01. This is a significant cost to patients.

ENSURE GREATER CONSISTENCY IN AMBULANCE FEES

We recognize that ambulance fees vary across the province and that rural residents can face a great cost burden. Given the increasing concentration of more specialized hospital services in larger centres, many patients are transferred from a rural hospital to an urban hospital. Patients are responsible for paying the fees for these transfers.

- We will introduce provincial regulation for road ambulance fees to ensure greater consistency across the province. As resources allow, we will move to lower the cost of inter-hospital transfers.

BETTER EMERGENCY SERVICES

We know that quality emergency medical services are important to Saskatchewan people.

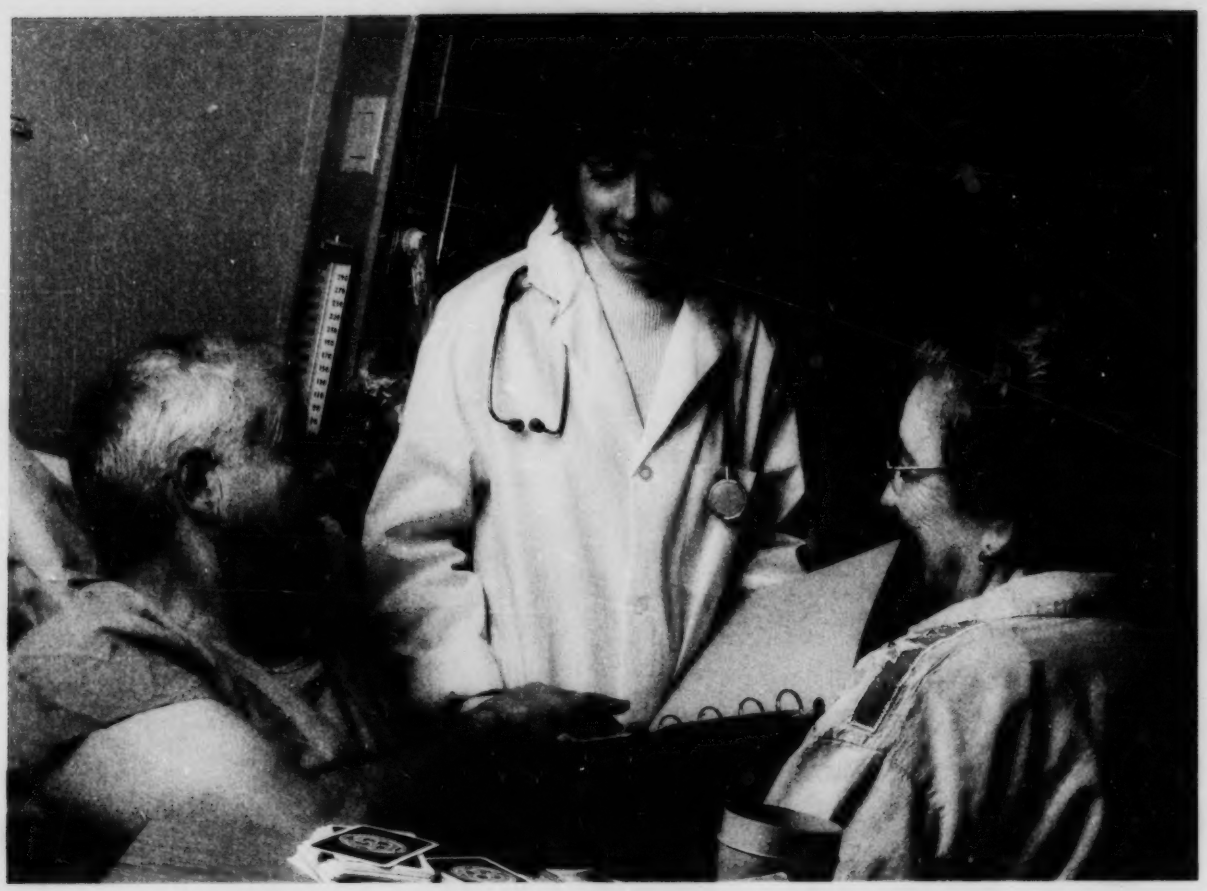
Our first priority will be to expand training for EMTs. Handling all ambulance calls from the wide-area dispatch centres is also a priority. Performance-based contracts between Regional Health Authorities and the wide-area dispatch centres will be signed in 2002.

As funding allows, we will improve response times in targeted remote areas.

We will also move ahead in the coming year to regulate ambulance fees. Our long-term goal is to establish a new ambulance fee structure to reduce the cost of inter-hospital transfers to patients.

Ultimately, Saskatchewan people can expect a better emergency medical system, one that offers:

- more highly skilled health providers on every ambulance;
- better co-ordinated dispatch that ensures the best possible use of every ambulance and EMS provider, and the quickest response possible for all residents;
- improved response times in rural and remote areas; and
- more consistent ambulance fees for every resident of the province.



The Plan For Better Hospital Care and Long-Term Care

Saskatchewan people depend on quality hospital services. Our province has a large number of hospitals that deliver a wide range of services—from complex surgeries to everyday medical care.

To strengthen our hospitals for the future, we will better define each facility to ensure that they focus on their strengths. To do this, we will designate hospitals as Community, Northern, District, Regional or Provincial, with minimum service levels for each category. We do not plan to close or convert any hospitals.

With respect to long-term care, we will provide more options for seniors and people with disabilities who want to remain independent in the community. This includes encouraging further expansion of supportive living arrangements such as personal care homes.

THE CHALLENGE OF IMPROVING HOSPITAL CARE

Hospitals have always been an important part of our health care system. They offer treatment when we are sick or injured, in a caring, safe environment. Even though new technologies have changed our use of hospitals over the years, our commitment to hospitals in Saskatchewan remains strong.

This year, our government provided $685 million to health districts to support hospital services. This amounts to about half of the total funding that districts receive from government.

We will always need a strong network of hospitals across our province. This plan helps us develop a clearer understanding of the role of hospitals, and establish a balance between access to care, quality and sustainability.

HOSPITALS IN SASKATCHEWAN

Saskatchewan has 67 hospitals in 64 communities, as well as the rehabilitation centre in Regina and the provincial psychiatric hospital in North Battleford. Three other hospitals are currently operating as health centres. In addition to the hospital system, the Saskatchewan Cancer Agency provides outpatient radiation and chemotherapy, as well as some screening programs.

Hospitals across our province vary widely. By far, small community hospitals make up the largest number of hospitals in our province. They fill an important role for local residents, providing basic medical and emergency services, a place to recover after surgery or a bed for observation.

We have a number of "mid-sized" hospitals in our smaller cities. The services in these hospitals can vary widely depending on the size of the community. In general, they offer a range of basic medical services and commonly needed surgeries and diagnostic tests, giving residents other options besides travelling to Regina or Saskatoon.

Our biggest hospitals in Regina and Saskatoon offer a wide range of specialized care and are a valuable resource to all Saskatchewan people. They have the necessary volume of patients and the critical mass of doctors and other health care providers needed to deliver quality, highly specialized programs.

Each of our hospitals is valuable in its own way. Each does a number of things well. We need to focus on those strengths.

FOCUSING ON STRENGTHS

Delivering specialized services is very complex. It requires advanced equipment and skills, as well as the right physicians and nurses and other providers with special training. Specialists need to treat enough patients to keep up their skills. They also need the support of their peers.

In some mid-sized centres, specialized services such as eye surgery or bone and joint surgery often rely on just one surgeon. This can result in occasional lapses in services. For example, hospitals may not be able to provide emergency surgery or intensive care on a 24/7 basis during the summer or on holiday weekends and may have to transfer or divert patients. This can affect both quality and public confidence.

Smaller hospitals often face the same dilemma in trying to sustain even more basic services. Often their ability to operate as a hospital can depend on a single health

"With quality as the priority, the existing trend to centralize specialized services will continue. Concentrating specialists in a few locations offers many advantages: an adequate volume of patients to allow them to retain their skills, availability of backup, and opportunities for professional growth. These are important factors for recruiting (of specialists), and essential for quality."

Commission on Medicare Report

provider. If a town's sole doctor retires or moves away, or if a nurse leaves, the hospital may not be able to function. This is a common occurrence, given the ageing workforce and problems attracting health professionals, especially to small towns with shrinking populations. At times, some hospitals have to operate as health centres due to a shortage of key health providers.

Saskatchewan people want good access to hospitals and they want services to be dependable and of high quality. They also realize that every hospital cannot be all things to all people.

It comes down to each hospital focusing on what it does best. This is a key to providing reliable, predictable hospital services so people know what they can expect 24 hours a day, 365 days a year.

While not all hospitals will offer the same kinds of services, reliability means:

- it is widely understood which services each hospital offers; and
- these services are always there when needed.

The Action Plan

Our health plan establishes new hospital categories and outlines a standard array of services that should be available in each hospital.

ESTABLISH NEW HOSPITAL CATEGORIES

Hospitals will be grouped into the following five categories, and will work together as a network to provide the full range of services people need. All hospitals are included in a category except for the provincial psychiatric hospital in North Battleford and the rehabilitation centre in Regina, as they have specific specialized functions.

Community Hospitals – Hospitals in 44 communities with a population of less than 3,500.

Northern Hospitals – Hospitals in four northern communities.

District Hospitals – Hospitals in nine communities with populations ranging from more than 3,500 to about 15,000.

Regional Hospitals – Hospitals in six communities with populations ranging from about 15,000 to 40,000.

Provincial Hospitals – The five major hospitals in Saskatoon and Regina.

These five categories set out a clear structure for hospitals within the larger health system and outline the level of services to be provided. This service delivery framework (see Appendix 1) will ensure quality, predictable hospital services and help guide decisions about where to invest new funds.

This plan does not call for any hospital closures or conversions. It does recognize, however, that as our health care system and communities continue to evolve, there will be ongoing service changes to reflect changing populations or service needs.

SUPPORT COMMUNITY HOSPITALS

The Fyke report called for a vastly simplified network of hospitals in Saskatchewan. It concluded that if primary health services and emergency medical services were strengthened in smaller communities, up to 50 hospitals could be converted into health centres. This was consistent with the report's finding that quality and efficiency should take priority over convenience.

We believe this goes too far. We believe there is a need for strong community hospitals.

In a province where rural communities are separated by large distances, people depend on having local access to basic hospital care. There is a sense of confidence that comes from having a hospital nearby.

Community hospitals are located in 44 communities with populations less than 3,500. They focus on:

- **24/7 emergency services;**
- **general medicine;**
- **basic lab and x-ray services; and**
- **observation, assessment, convalescent and palliative care.**

There are many hospital services that can be delivered locally. Seniors suffering from pneumonia, people recovering after surgery in the city, or patients with chest or stomach pains who need observation all benefit from community hospitals.

Currently there are 46 small hospitals in communities of fewer than 3,500 people, including two in the North. Our plan does not call for any hospital closures or conversions. However, we all know that our province and the delivery of health care, will continue to change. As well, people will continue to make choices to seek care in larger centres. Over time, communities may find it necessary to look at other options due to factors such as:

- difficulties in retaining a minimum number of physicians and nurses;
- a shrinking population;
- ability of other nearby hospitals to admit more patients;
- disruptions in providing 24/7 services due to lapses in staffing, particularly during the summer or holiday week-ends;
- declining levels of service volumes; or
- ability to better meet local needs through other kinds of service delivery.

Where a facility change is contemplated, government, Regional Health Authorities and communities will work closely together to evaluate the care that is needed and how it can best be provided. Community Advisory Networks can help local residents have a voice in these decisions. This will ensure the right changes are made, for the right reasons. The changes will be unique to the individual community and yet reflect a consistent provincial framework.

SUPPORT NORTHERN HOSPITALS

We recognize that delivering hospital care in northern Saskatchewan is a unique challenge. Our plan supports maintaining four northern hospitals, including a new hospital in Stony Rapids. This hospital will be completed in 2003 and replace the facility in Uranium City which is currently operating as a health centre. Planning is also underway for a new hospital in Ile a la Crosse.

Northern hospitals are supported in four communities with populations ranging from about 1,500 to 4,500:

- **La Ronge, La Loche, Ile a la Crosse and Stony Rapids (by 2003).**

Essentially, northern hospitals provide the same array of services as community hospitals. To recognize the unique challenges in the North, the government offers special programs to assist northern communities in retaining and recruiting the health providers they need to support a wide range of services. In addition, telehealth services (video links to specialists in larger communities) are a high priority. Further discussion of services in the North is included in The Plan for Northern and Aboriginal Health.

SUPPORT DISTRICT HOSPITALS

Community and northern hospitals can meet a wide range of people's everyday needs. But when residents require the next level of service, for example low-risk childbirths, it makes sense for this to be available close to home.

Our plan supports district hospitals in nine communities with populations of about 3,500 to 15,000. Because these are larger communities, they can maintain a larger roster of physicians and deliver a wider range of services.

District hospitals are supported in nine communities with populations of about 3,500 to 15,000 people:

- **Estevan, Weyburn, Meadow Lake, Melfort, Humboldt, Nipawin, Kindersley, Melville and Tisdale.**

District hospitals will be expected to provide a standard minimum level of service that includes:

- 24-hour emergency services;
- general medical services for adults and children;
- low complexity surgeries; and
- low-risk deliveries of babies.

These services would be predominantly delivered by family physicians with additional training. Hospitals that are close to each other will need to work together to deliver the minimum level of service. For example, Estevan and Weyburn could make co-operative arrangements of this kind, as could Melfort, Tisdale and Nipawin or Melville and Yorkton. By working together in a "network," hospitals can support each other in providing the full range of care that people need in a geographic area.

SASKATCHEWAN HOSPITALS: SELECT DATA

Hospital Category	Community	Community Population 2001	Family Physicians September 2001 (a)	Specialists September 2001 (b)	Surgery Cases (Inpatient and Day Surgery) 1999/00	Births 1999/00	Acute Average Daily Census 1999/00	Acute Beds Staffed March 2001
Provincial (5)	Saskatoon (3 hospitals)	209,264	183	383	35,509	4,213	575	668
	Regina (2 hospitals)	187,441	163	212	31,411	3,050	501	598
Regional (6)	Prince Albert [c]	39,737	41	45	5,789	1,250	96	107
	Moose Jaw	34,236	23	28	4,499	444	62	99
	Lloydminster [d]	22,599	11	11	1,922	556	45	51
	North Battleford	19,661	16	19	2,301	334	58	75
	Yorkton	16,899	13	19	4,421	584	71	78
	Swift Current	16,100	19	18	2,425	376	57	86
District (9)	Estevan	10,905	12	1	695	287	36	53
	Weyburn	10,139	10	3	454	134	24	50
	Meadow Lake [c]	6,298	10	0	476	335	20	34
	Melfort	5,970	9	3	1,257	118	20	42
	Humboldt	5,572	9	1	692	150	34	36
	Nipawin	5,024	8	1	297	142	23	38
	Kindersley	4,887	3	0	228	95	14	16
	Melville	4,650	4	1	334	34	24	30
	Tisdale	3,506	5	0	246	57	15	24
Northern (4)	La Ronge	4,436	8	0	25	106	10	22
	La Loche	2,874	4	0	0	3	4	12
	Ile a la Crosse	1,551	2	0	4	18	5	22
	Stony Rapids [f]	(under construction)						
Community (44)	Assiniboia	2,777	3	0	0	9	9	17
	Rosetown	2,723	5	0	155	25	14	19
	Esterhazy	2,681	3	0	8	0	11	18
	Maple Creek	2,609	3	0	8	17	7	21
	Moosomin	2,560	6	0	20	21	19	33
	Biggar	2,488	3	0	5	3	9	20
	Unity	2,425	3	0	8	13	6	11
	Outlook	2,401	2	0	0	0	7	13
	Canora	2,396	4	1	12	0	15	16
	Hudson Bay	2,260	4	0	0	14	7	10
	Fort Qu'Appelle	2,246	5	0	0	2	11	12
	Wynyard	2,141	5	0	3	2	6	8
	Watrous	2,099	3	0	1	0	3	4
	Shaunavon	2,050	2	0	1	26	5	21
	Kamsack	2,048	3	0	144	17	18	20
	Indian Head	1,927	2	0	3	2	7	16
	Shellbrook	1,584	4	0	1	14	13	19
	Rosthern	1,548	5	0	12	56	15	31
	Wadena	1,437	3	0	1	1	8	21
	Lanigan	1,437	2	0	5	0	3	4
	Foam Lake	1,319	1	0	0	0	4	4
	Gravelbourg	1,283	2	0	1	0	6	9
	Preeceville	1,236	1	0	9	1	9	10
	Kerrobert	1,216	2	0	3	0	4	6
	Maidstone	1,178	1	0	1	11	14	23
	Spiritwood	1,156	3	0	1	6	7	12
	Davidson	1,131	1	0	0	0	3	2
	Kelvington	1,086	2	0	0	0	4	14
	Kipling	1,069	3	0	1	1	11	20
	Big River	1,043	1	0	0	1	3	9
	Wakaw	1,041	2	0	14	7	13	22
	Redvers	1,023	3	0	13	14	7	14
	Porcupine Plain	988	2	0	0	9	4	10
	Leader	987	2	0	2	2	9	23
	Wolseley	875	2	0	1	14	9	19
	Herbert	858	1	0	3	0	9	14
	Broadview	638	3	0	4	12	6	18
	Balcarres	637	1	0	5	0	7	10
	Turtleford	601	2	0	0	0	5	23
	Arcola	582	1	0	4	3	9	13
	Paradise Hill	582	1	0	0	0	5	14
	Central Butte	509	2	0	0	0	6	9
	Loon Lake	406	1	0	1	0	2	13
	Lestock	188	2	0	17	1	7	10
Hospitals operating as health centres (3)	Wawota [e]	608	0	0	3	0	4	0
	Hafford [e]	469	1	0	1	0	2	6
	Uranium City [e] [f]	176	1	0	0	0	0	0
		677,215	**668**	**748**	**93,458**	**12,890**	**2,053**	**2,802**
ALL SASKATCHEWAN (covered by Saskatchewan Health)		**1,024,788**	**715**	**747**				

(a) Family physicians (or general practitioners) who were active as of September 18, 2001. "Active" physicians are those who earn $12,500 or more in Medical Services Plan payments in the quarter and are still in practice on the last day of the quarter. This also includes physicians on an alternate funding arrangement who submit more than $12,500 in shadow billings.
(b) Specialists with active Medical Services Plan billing numbers. Specialists who practice in more than one location are registered in the community where they earn the majority of income, or (for those on contract) in the largest community.
(c) Among Regional and District hospitals, Prince Albert and Meadow Lake treat a high percentage of referrals from northern communities.
(d) The population of Lloydminster includes Lloydminster, Alberta. Family physician total excluded approximately 18 general practitioners who bill through Alberta Health.
(e) Wawota, Hafford and Uranium City are currently operating as health centres due to lack of staff and/or physician coverage.
(f) Uranium City Municipal Hospital will be replaced by a new hospital being built in Stony Rapids. Construction is expected to be complete in 2003.

To support district hospitals, our plan calls for the following actions:

- training and recruitment strategies that result in reliable delivery of the minimum level of required services; and
- expanded telehealth services linking more patients and doctors in rural communities with specialists in regional and provincial centres.

SUPPORT REGIONAL HOSPITALS

Asking people to drive to Regina or Saskatoon for every kind of surgery or specialized care is not practical.

Many of the more basic services such as general surgery (e.g. gall bladder removal or hernia repairs) can be provided in regional centres, improving access while still ensuring quality and sustainability.

Exactly what services should be provided outside of Regina and Saskatoon has been a topic of debate for some time. In 1997, an expert working group found that to deliver safe, quality specialty services, hospitals should have a minimum of three physicians in each speciality area, and should provide around-the-clock services, 365 days a year, in basic specialties.

The Commission on Medicare report noted that some hospitals now offer surgical programs (e.g. bone and joint surgery) with only one or two surgeons. The report noted these surgeons are on call for extended periods, making recruitment difficult and leading to burnout. It concluded that "These are not sustainable programs."

Based on these findings, our plan identifies and supports hospitals in six communities that will be classified as "regional hospitals." The plan identifies a minimum array of services that a regional hospital must deliver. Regional hospitals are further divided into two levels, based on community population.

Regional hospitals – Level 1
communities of between 30,000 and 40,000 people:

- **Prince Albert and Moose Jaw.**

Regional hospitals – Level 2
communities of between 15,000 and 30,000 people:

- **Lloydminster, North Battleford, Swift Current and Yorkton.**

All six regional hospitals will provide the minimum range of services found in district hospitals. They will also provide reliable basic specialty services. These include internal medicine, general surgery, obstetrics and gynecology. These hospitals will also offer intensive care services.

"...the location of specialty services cannot be decided by popular choice. Their siting and medical supervision must be carefully planned to ensure medical viability, sustainability over time and high quality. A province-wide plan for specialty services needs to be laid out."

Saskatchewan Association of Health Organizations submission to the Commission on Medicare

Each regional hospital will work to maintain a minimum of three physicians with additional training in each discipline and offer on-site radiology services.

In addition to the basic specialties, regional hospitals will have the ability to provide an even wider range of services. These include secondary specialty services such as orthopedics (e.g. operations of the bone structure such as hip and knee replacements) and eye surgery.

Regional hospitals can only develop this secondary level of services once they have reliable basic specialties in place, once they have the resources to support secondary services and once there is sufficient need. Currently, only the Level 1 regional hospitals in Moose Jaw and Prince Albert have met these criteria.

The Level 2 regional hospitals have had varying success in recruiting specialists. Future investments and recruitment strategies in these hospitals must focus on attracting the minimum number of basic specialists before they can deliver secondary services. A provincial review process will be put in place to look at these requests. This review will focus on ensuring a safe, quality, and sustainable service. The desire for convenience or community status cannot be permitted to drive planning at the expense of safety and quality.

To support regional hospitals, as funding allows, our plan calls for the following actions:

- establish CT scan services in four additional regional hospitals (Level 2); and
- use alternate payment plans to recruit specialists.

STABILIZE PROVINCIAL HOSPITALS

People throughout Saskatchewan rely on hospitals in Regina and Saskatoon for many specialized services. These include diagnostic tests such as MRI scans and a wide range of surgeries and specialized medical services such as cancer treatment, heart surgery or intensive care for infants.

These five hospitals are important to all Saskatchewan people. They are the only hospitals with high enough patient volumes to sustain more specialized programs.

Provincial hospitals in Regina and Saskatoon perform 72 per cent of all surgeries in Saskatchewan. Many of their patients come from outside the two cities.

Being a provincial resource comes with a price tag. Both the Regina and Saskatoon health districts have faced many pressures in trying to offer the provincial services that are needed. Some specific pressures include increasing demand for services, the need for new medical equipment, and the need for better information to ensure best outcomes and optimal use of resources.

To ensure Regina and Saskatoon can run true "provincial hospitals" with a good supply of the requisite health providers, we will support them by:

- committing to stable operating funding by increasing base funding;
- providing additional funding to replace medical equipment;
- ensuring better management of hospital resources through improved information; and
- continuing efforts to keep and attract physicians, nurses and other health professionals.

For highly specialized services where few procedures are done, it makes sense to deliver these on a provincial basis or even on a Western Canadian basis. We will work with Regina, Saskatoon and other Prairie cities to create networks to allow consolidation of some programs.

THE CHALLENGE OF IMPROVING LONG-TERM CARE

One in seven residents in our province is over the age of 65. Many Saskatchewan seniors are independent and benefit from the support of family and the community. We recognize that as seniors age, they often need support and care to manage in their daily lives. Other residents, such as those with disabilities or illness, may need ongoing support as well.

The people of Saskatchewan are committed to providing the best long-term care possible, and supporting seniors and others in their homes and communities is a top priority. Depending on their needs, seniors and others have a wide range of options:

- **Home care.** This can range from housekeeping or personal care (help with bathing or dressing) to daily meals, nursing care, respite care, and training and support of family members who help provide care. Currently, about 30,000 Saskatchewan people receive home care services. While there is no charge for nursing care or professional therapy services, clients pay a fee for other services based on their income. Overall, government covers more than 90 per cent of the cost of delivering home care.

- **Assisted living.** Seniors in certain private and public housing units can get help with services such as housekeeping, laundry and meals, helping them remain in their own homes for longer.

- **Personal Care Homes.** These are privately run homes (including for-profit, non-profit, community or co-operative) that provide another option for seniors or others who want some support but do not need or want nursing home care. There are about 2,400 beds in about 260 personal care homes throughout the province. Residents pay the full cost of their accommodation and care.

- **Special Care Homes.** Also known as nursing homes, special care homes provide the heaviest level of care for those who need it. Our province now has 157 of these homes and about 35 other long-term care units in hospitals. In total, they provide care to about 8,900 residents. These residents pay a monthly fee based on their income. Overall, the government covers about 75 per cent of the cost of nursing home care.

PROVIDING MORE CHOICES IN HOMES AND COMMUNITIES

We know that many seniors and people with disabilities are not eager to leave their homes. They want to protect their independence. They want to live on their own for as long as they can. Our government is supporting this desire. Over the past few years, we have expanded options to nursing homes. For example, funding for home care has grown by 165 per cent in the past 10 years. This has allowed thousands more people to use these services.

In the past five years, the Saskatchewan Assisted Living Services (SALS) program was introduced through Municipal Affairs and Housing for seniors in social housing. This program offers daily living supports for seniors, helping them remain in their homes and delay the need for a move to a nursing home.

Personal care homes have also expanded over the past decade, offering supportive housing to an additional 450 residents. By expanding these community options, our province has been able to offer a greater range of choices to Saskatchewan seniors and others who need support.

The Action Plan

We will give seniors and people with disabilities more options to remain independent.

Specific actions will include:

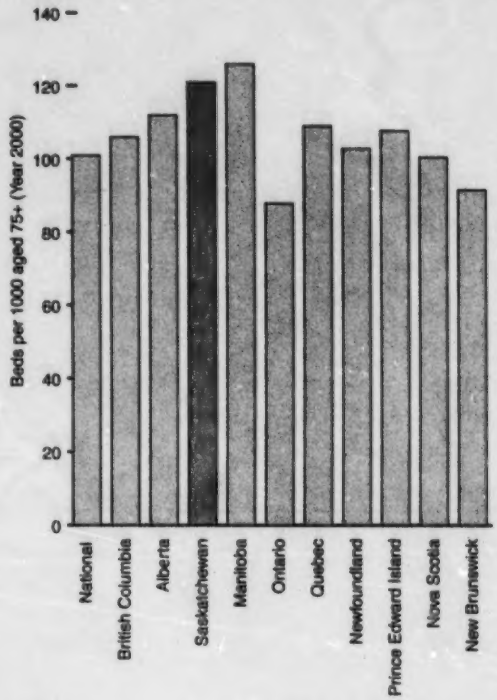
- allowing the development of more personal care homes. We will eliminate the 40-bed limit on these homes. According to some home operators, this would encourage the "for profit" and "not for profit" sectors to open more homes. While allowing for larger homes, we will expand regulatory monitoring to ensure quality for residents;

- supporting Saskatchewan Municipal Affairs and Housing in introducing Saskatchewan Assisted Living Services to more seniors in social housing throughout the province. This would assist more seniors to remain in the community longer, diminishing their need to move into personal care homes or special care homes; and

- providing an individualized funding option. This would primarily benefit those who need a high level of attendant services at various points in the day over a long period of time. For example, an adult with a disability may want to consistently receive care from one provider. The health care system could provide that person with funding to hire his or her own provider.

We expect that, as these options are increased, the need for nursing home beds will continue to drop. It is important to note that, compared to other provinces, Saskatchewan has a high number of beds. In the year 2000, we had 121 beds for every 1,000 residents aged 75+. This is well above the national average of 101 beds per 1,000 residents aged 75+ and second highest among the provinces. A bed in a nursing home is very expensive. On average, it costs about

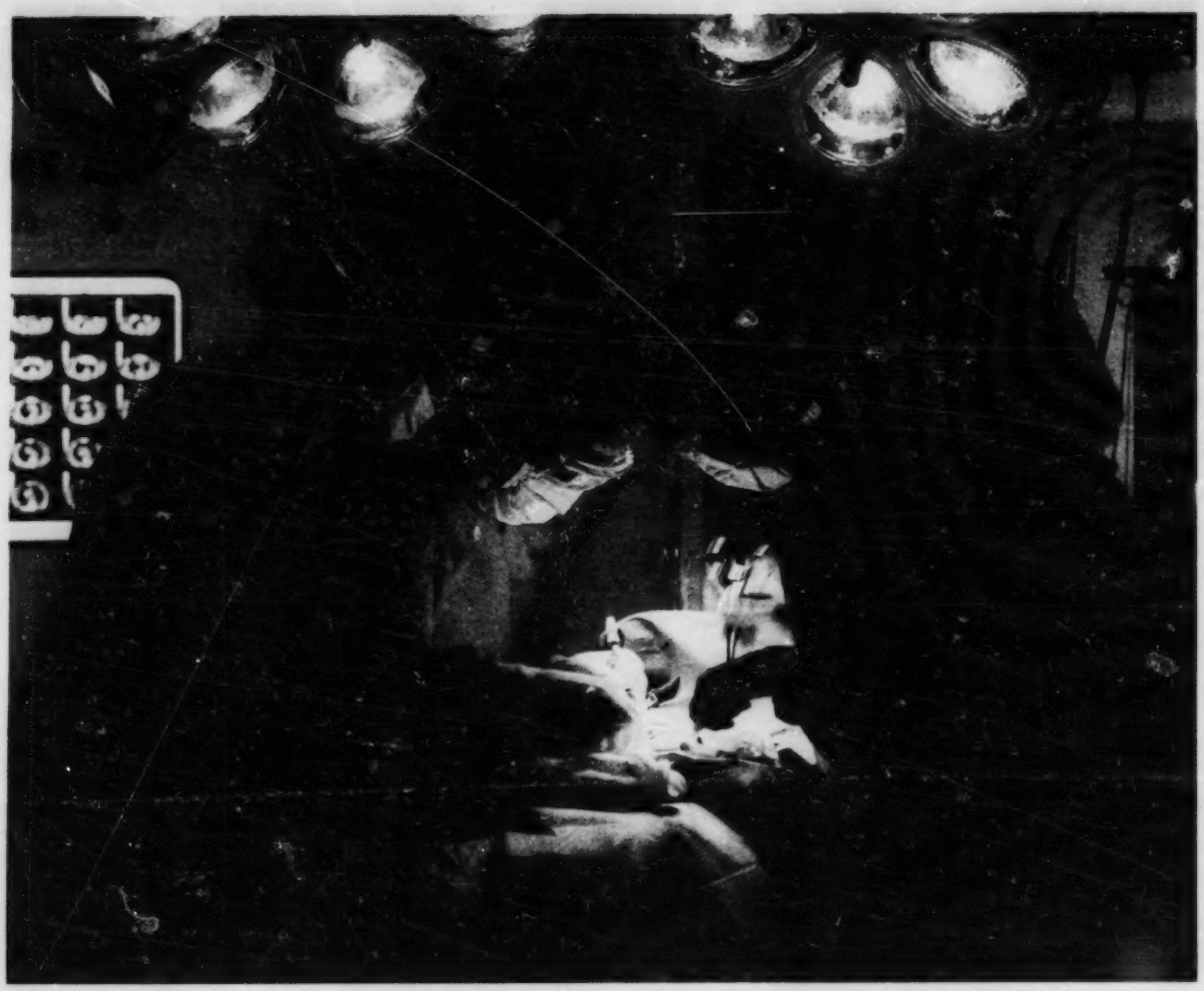
NURSING HOME BEDS ACROSS CANADA



$48,000 a year to operate one bed, compared to an average of about $3,000 per client to provide home care.

According to the Commission on Medicare report, "Estimating the appropriate number of beds is not easy. Given its dispersed population and long distances between small communities, Saskatchewan must take into account the desire for local access. The need for beds also depends on the availability of other housing and service options."

Our health plan will significantly increase those other options. Ultimately, this may further reduce the need for nursing home beds, allowing our province to focus on providing seniors with a greater range of community-based choices.



The Plan To Reduce Waiting Times

Waiting times for surgery are a major concern for Saskatchewan people. Unfortunately, there are no easy answers. The wait list system cannot be improved overnight, and keeping and attracting key health providers remains a critical factor. But there are a number of other actions we need to take.

Our health plan includes providing more money to our major surgical centres and improving co-ordination of waiting lists. As well, we will ensure our doctors use a standard "measuring stick" to decide who needs surgery, and who needs it first. And finally, we will break down the air of mystery around the surgical system by providing people with clear information so they know where they stand on the list and how they can ensure the shortest possible wait.

A LIGHTNING ROD FOR PUBLIC CONCERN

It seems almost everyone in Saskatchewan knows someone who has gone through a stressful time waiting for surgery or a diagnostic test.

Concern over waiting times is high. People are frustrated by a system that does not seem to be working. They feel powerless. "You are just a letter from the alphabet when your name goes to one of the major centres and onto a wait list," said one resident during public consultations.

Many people argue that the solution is to spend more money and to hire more doctors. The experience from other provinces and countries says it is not that simple. There are many factors behind waiting times that cannot be quickly resolved. Nonetheless, by working together on a number of long-term actions, we can make progress toward a more reasonable, fair surgical system that earns the confidence and trust of Saskatchewan people.

VOLUMES OF SURGERIES IN SASKATCHEWAN

Every year, around 93,000 surgeries are performed in Saskatchewan. That amounts to about 255 surgeries every day.

About 72 per cent of these are done in Regina and Saskatoon. These cities provide a broad range of surgical services. The next five largest hospitals in Prince Albert, Moose Jaw, Yorkton, North Battleford, and Swift Current do 21 per cent of surgeries. The other seven per cent of surgeries are done in smaller hospitals around the province.

The total annual number of surgeries in our province has gone up by approximately 16 per cent compared to 10 years ago.

COMPARISONS WITH OTHER PROVINCES

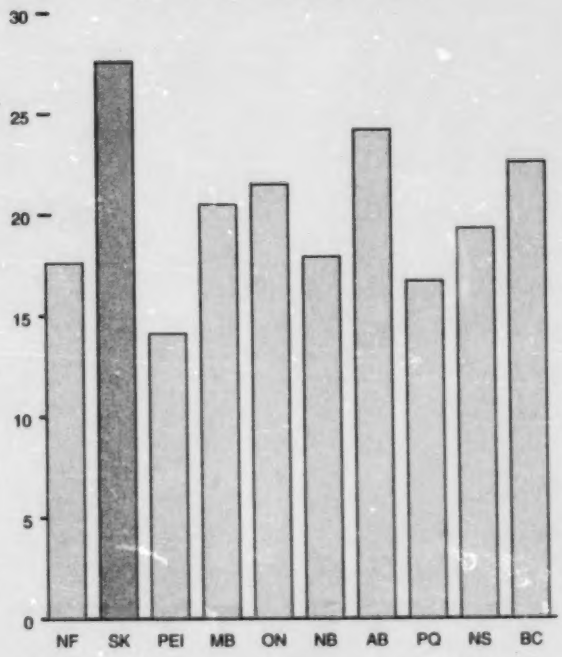
One of the difficulties in managing waiting lists is the lack of good information about the surgical system. We do know, however, that in some specialties we are doing surgeries at higher rates than in other provinces.

For example:

- In 1997-98, rates of hip and knee replacements in Saskatchewan (per 100,000 population) were the second highest in Canada (age-sex adjusted).
- The most recent comparable data shows Saskatchewan had the highest rate of cataract surgery in Canada (age-sex adjusted).

CATARACT SURGERY RATES

Age-Sex Adjusted Surgery Rates per 1000 Residents Aged 50+, 1995/96-96/97



Source: Roos and Fransoo, University of Manitoba

For some other types of surgery, our per capita volumes of surgery are more in keeping with those in other provinces. When it comes to gall bladder removals or hernia repairs, for instance, Saskatchewan ranks in about the middle of the pack.

WHO IS WAITING FOR SURGERY IN SASKATCHEWAN?

Patients who need surgery are classified in one of three broad groupings:

Emergent – This is an "emergency" situation. The patient needs surgery because of a life-threatening situation. People in this category get surgery as soon as possible, usually within hours. They are not put on a wait list. About half of all heart surgery is done on an emergency basis.

Urgent – The patient is not in a life-threatening situation but surgery must be done in a short period of time. Most cancer cases are treated as "urgent" and handled within target timelines of two to three weeks. Patients are closely watched by their doctor and can be changed to "emergent" if their condition changes.

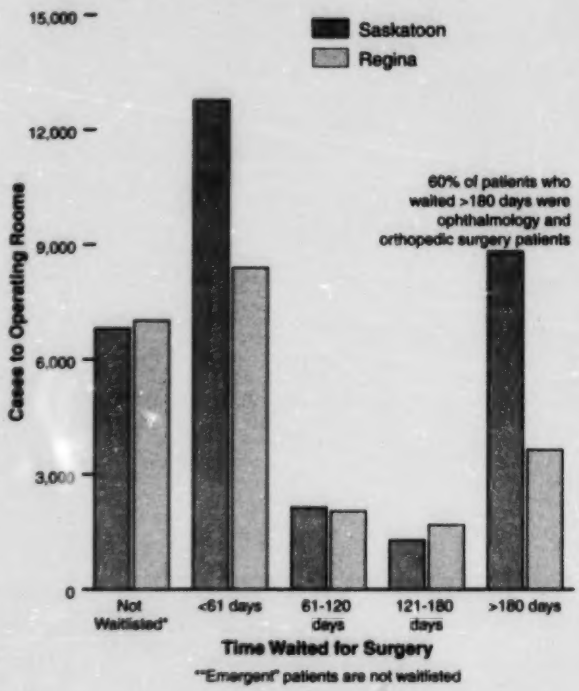
Elective – Most of the people on wait lists are booked for "elective" surgery. These people need surgery to improve their health or quality of life. While their condition may be painful or affect their lifestyle, it is not considered as an immediate threat to their health or life.

Almost half the patients on wait lists for elective surgery are waiting for either eye surgery (e.g. cataracts) or orthopedic surgery (e.g. hip or knee replacements).

HOW LONG ARE PEOPLE WAITING?

An analysis of waiting times in Regina and Saskatoon from the year 2000 shows that almost two thirds of patients got their surgery in less than two months.

NUMBER OF DAYS WAITED FOR SURGERY, 2000



Of the people who waited longer than six months for surgery, about 60 per cent were waiting for orthopedic (e.g. hip or knee replacement) or eye surgery (e.g. cataracts).

While we can make some comparisons of surgical volumes with other provinces, it is very difficult to compare waiting times. Currently, individual hospitals, doctors and health regions keep their own data, often in different forms. Pulling it all together to improve performance is one of our major challenges.

FACTORS BEHIND WAITING TIMES

There are several complex factors that can influence how many patients are waiting for surgery and, more importantly, how long they wait. In its simplest form, it comes down to "supply" and "demand."

On the supply side, we need enough money to pay for equipment, facilities and the many health care providers required to provide surgery. We need to have the right health care providers in place – an ongoing challenge in Saskatchewan and everywhere else. Shortages of operating room nurses or specialists such as anesthetists can affect the volume of surgeries.

The availability and co-ordination of equipment, beds and operating rooms can affect the delivery of surgery. There are process issues as well – if the booking system for surgeries does not work well, this affects supply.

There are also many factors that can affect demand for surgery. First, the age of our population is increasing. Since 1981, we have seen a 62 per cent increase in the number of seniors over the age of 75. This has meant a greater need for services like cataract and hip or knee surgery.

Improved technology can increase demand. For instance, over the years, cataract surgery has become less risky and can be used on a wider range of patients, and so more patients are getting booked for this surgery. As a result, the number of cataract surgeries done in 2000 was twice as high as those done in 1990. Still, the number of people waiting continues to grow.

Doctors also determine the threshold for surgery (i.e. the point at which patients are put on a list for surgery). As technology improves and reduces the risks of surgery relative to the benefits, more people become candidates for surgery, increasing demand.

Finally, wait lists are generally poorly co-ordinated in the province. Often, individual specialists keep their own wait lists and these lists are not audited on a regular basis. This means that some patients may be on two or more lists for the same procedure, not know they are on a list, or remain on a list even though they have decided not to have surgery.

To improve the wait list system, we need to work together to address all of these factors.

The Action Plan

Our health plan will ensure more reasonable, fair and predictable waits for our residents through four key strategies. Some of these strategies contain actions already underway. Some have new actions. To achieve them, we need the co-operation of all our partners in the health system.

IMPROVE SURGICAL CAPACITY

- We will expand efforts to keep and attract key health providers to support delivery of surgery.
- We will continue to offer re-entry training to help general practitioners retrain as specialists and to help nurses who have left the profession re-enter it.

- We will more actively recruit across North America and around the world.

PROVIDE MORE SURGERY FUNDING

- We will continue the $12.5 million annual Wait List Fund. This money, provided to surgical centres, helps fund medical equipment and opening of additional operating rooms.

- We will provide targeted funding to Regional Health Authorities to renovate and equip operating rooms.

- In addition to the Wait List Fund of $12.5 million, we will commit to increase funding to those hospitals that provide the majority of surgeries. This includes funding to support health provider salaries and medical and surgical supplies, essential elements in delivering stable volumes of surgery.

DEVELOP A PROVINCE-WIDE SURGICAL WAITING LIST

- We will create a province-wide surgical waiting list to track all patients needing surgery in the province.

- This wait list will be routinely audited to reduce duplication and bookings for patients who no longer require surgery.

IMPROVE FAIRNESS AMONG PATIENTS

- We will develop province-wide guidelines to ensure patients are assigned priority for surgery based on need.

- We will use clinical tools to assess patients to determine their need for different kinds of surgery. For instance, patients needing a hip or knee replacement would be assigned a score by their doctor based on various criteria (e.g. pain level, loss of mobility). This score could be peer reviewed and compared against those for other patients – even those seeing specialists in other cities – ensuring a fair ranking on the waiting list.

- The Western Canada Waiting List Project has already developed some priority-setting tools for general surgery, hip and knee replacements and cataract surgery. We are now looking at how we can work together with specialists to adopt such tools and consistently use them in making treatment decisions.

> *"SAHO strongly supports the concept of developing standards based on research and clinical evidence so that surgeries and tests are provided only when needed and people waiting would be assigned priority based on need."*
>
> Saskatchewan Association of Health Organizations submission to the Standing Committee on Health

- Assessment tools will also help us develop acceptable waiting time targets for different types of surgery. This will allow people to know if they are getting their surgery on time.

PROVIDE BETTER PUBLIC INFORMATION

- We will establish a waiting list web site for Saskatchewan people. The web site will be online by the spring of 2002. It will provide information on how the surgical booking system works, how long people can expect to wait for certain procedures and how they can ensure the shortest possible wait.

  In the long term, we hope to further develop the web site to include separate waiting times for each specialist and give patients more information to assess their personal situation.

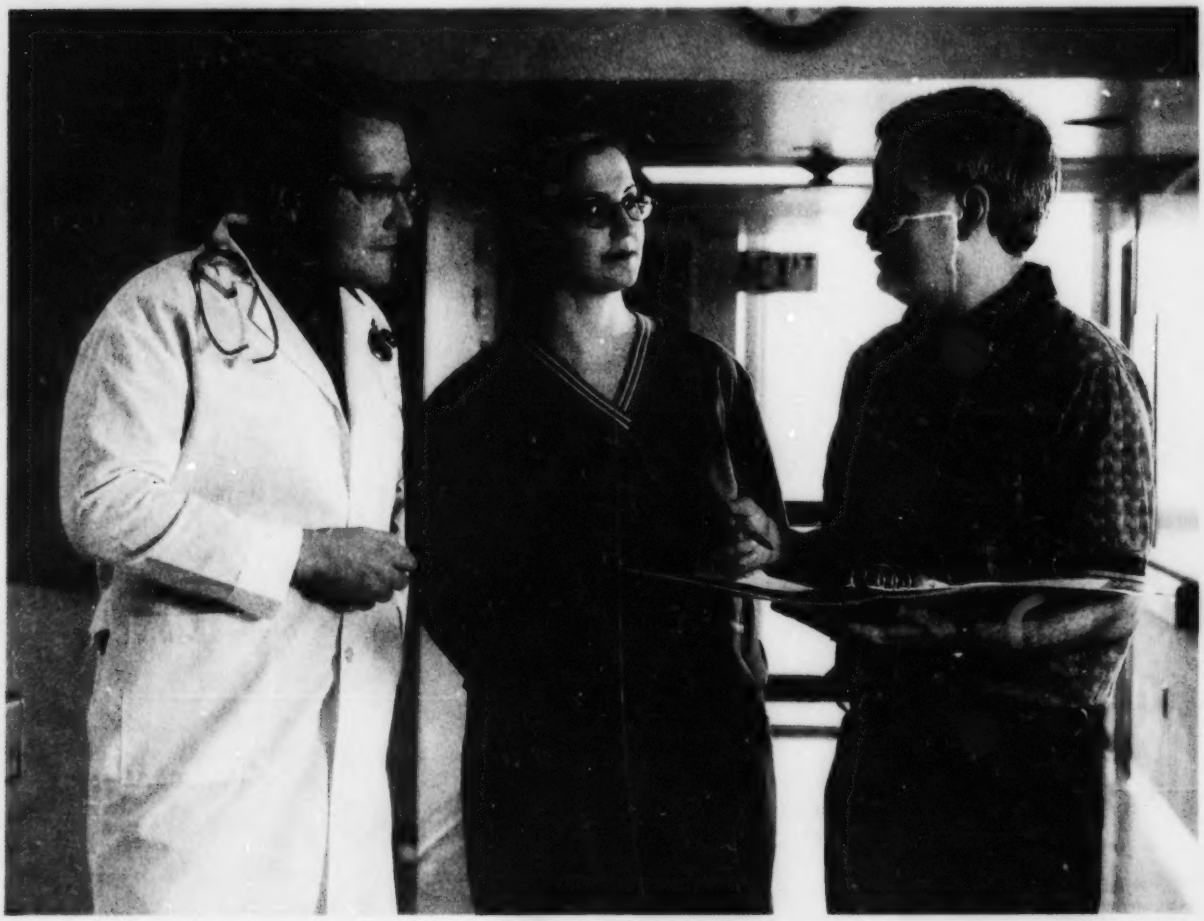
- We will provide the public with key contact people. Both Regina and Saskatoon will have a surgical information specialist through a toll-free number. Other smaller surgical centres will provide a key contact person. These contacts will work closely with existing District Quality of Care Co-ordinators, and will be able to answer patients' questions about the system (e.g. where they are on the waiting list).

A BETTER SYSTEM FOR PATIENTS

Improving the surgical system is a long-term goal. Ultimately, we want to create a system that earns greater confidence and trust from patients. For instance, people will feel confident if they know that their need for surgery has been measured through a standard scoring system, and that they will be given a fair priority on the list. They will also be able to talk to their family doctor about waiting times for various specialists in various locations and choose what is right for them.

Our provincial and regional centres will have the stable funding they require to deliver needed surgeries. The government, Regional Health Authorities, doctors and other partners will all work together to ensure the best possible use of operating rooms and other resources.

We will be able to attract key health providers by offering good workplaces, a fair system for operating room bookings, and up-to-date surgical equipment. Just as important, patients will be able to consult the wait list web site and stay in touch through a toll-free number to know where they stand.



The Plan To Retain, Recruit and Train Health Care Providers

Meeting the future need for nurses, doctors and other health professionals requires a province-wide human resources strategy focused on keeping the providers we have, increasing training opportunities, and allowing health professionals to make full use of their skills and training.

Saskatchewan cannot just depend on attracting skilled personnel from outside our province – we must devote more resources to developing our local talent. Our health plan calls for a renewed mandate for the College of Medicine, increased investment in training and bursaries, and professional development for current staff. All play a part in a long-term strategy to retain existing providers, develop their skills and attract new health care workers. Another important focus will be developing a more representative workforce by attracting citizens of Aboriginal ancestry into health care.

A SIGNIFICANT CHALLENGE

Supporting, attracting and developing skilled personnel is the single largest challenge for Saskatchewan's health care system. With many health care workers in short supply, health care services are under stress.

In some cases districts have cut back on services because of difficulty in recruiting nurses, physicians and other key personnel. Health employers report that it is hard to fill vacancies because of a lack of full-time positions, shortages of qualified candidates, geographical remoteness and barriers in collective agreements.

The personnel challenges for the health system call for a variety of solutions. Some require a change in the way we deliver health care. Others relate to training, attracting and keeping skilled people to provide the services that we need.

SUPPORTING TEAMWORK IN A DYNAMIC WORKPLACE

Every type of health care provider has unique skills that contribute to better health. When these skills are not used to the fullest, we may be missing opportunities for enhanced services, or wasting valuable resources. In some cases, where more can be done without referral to a more specialized provider, we may be missing the opportunity to provide services closer to home. In other cases, we may be paying more for services if we are asking one provider to do what another could do at a lower cost.

Recently, providers have been taking on new roles – licensed practical nurses are administering medications more often; advanced practice nurses are able to prescribe some medications; nurses are being trained to work as surgical assistants; and general practice physicians are developing specialized expertise. Despite these successes, barriers arise when unions or professional groups are focused on protecting jobs or maintaining an exclusive role in providing care.

> *"The Primary Health Services model is built on the principle of making the best use of the skills and training of all members of the team. Successful implementation of the model could easily be thwarted by professional turf protection and inflexible collective agreements.... Unions and professional associations will have to be creative and flexible partners in building a better workplace."*
>
> **Commission on Medicare Report**

Our plan will mean new opportunities for health care providers to use the full range of their skills. Rather than being threatened by change, workers can be assured they will benefit from new roles, new training and enhanced professional development.

Individuals and organizations will be invited to step out of existing patterns, and explore new ways of working together. Government will take the lead in identifying and removing barriers that prevent health care providers from using their training and skills to the fullest.

RETAINING AND RECRUITING THE PROVIDERS WE NEED

Across Canada and around the world, skilled health care workers are in great demand. We must be creative in finding ways to attract the personnel we need, particularly in rural and northern parts of the province.

For example, while the province has traditionally had a smaller number of physicians per capita than the national average, recent initiatives such as bursaries, improved working hours and support for continuing education have helped stabilize and increase our physician workforce. According to Canadian Institute for Health Information statistics, Saskatchewan has had a steadily increasing number of physicians over the past five years. Since 1996 our ratio of general practice physicians per capita has increased by 6.1 per cent, and the ratio for specialists by 6.4 per cent – increases that are much higher than the results for Canada as a whole. Turnover rates for physicians remain, however, unacceptably high.

Recruiting nurses is a challenge in a market with strong competition from the United States and other provinces. Shortages extend to many other occupations as well, including radiation technicians and sonographers, public health inspectors, respiratory therapists, audiologists and emergency services personnel, among others.

There are positive signs on the horizon. Saskatchewan added additional training seats for nurses in 1999, and graduates from the College of Nursing are increasing. In 2000, at least 74 per cent of nursing graduates took positions in Saskatchewan health districts, and in 2001 the number is close to 80 per cent. A re-entry bursary program was introduced in 2001 and has attracted over 100 nurses to re-enter the workforce or upgrade their skills.

We also have a whole host of initiatives and bursary programs for physicians, including resident and undergraduate medical bursaries, Rural Practice Establishment Grants, and continuing education supports, to name just a few. Saskatchewan Health also offers bursaries for students in other hard-to-fill health occupations.

> *"We need health human resources planning that covers all health providers. We need to implement a comprehensive, co-ordinated province-wide approach to health human resources planning that will examine all the human resources needed."*
>
> Saskatchewan Registered Nurses' Association

A REPRESENTATIVE WORKFORCE

A major challenge for the future is to have a representative workforce in Saskatchewan health care. Shortages of health care providers mean there are excellent job opportunities here at home for Saskatchewan citizens. We have a rich supply of talent to draw from, including the Aboriginal community.

Only a very small proportion of our health workforce comes from First Nations or Metis populations. Within the next 30 years, about one-fifth of the Saskatchewan population will be of Aboriginal heritage. This growing sector is an important resource as we work to meet future needs for health care personnel. Much more can

be done both within the workplace, and in training and education, to encourage Aboriginal participation in health care careers.

JOB SATISFACTION

Job satisfaction is a key component in retaining and attracting health care providers. Workplace morale has suffered from the disruption and change in health care in recent years.

In his report *Job Satisfaction, Retention, Recruitment, and Skill Mix for a Sustainable Health Care System*, Allen Backman identifies nearly 20 factors that affect workplace satisfaction in the health system. Factors ranging from workloads and physical environment to organization of work and interpersonal relations all play a part.

We have already begun to work with health care provider groups on strategies to make workplaces more attractive and supportive. These efforts must continue, and intensify.

MANAGING CHANGE IN THE HEALTH SYSTEM

The changes in the health plan represent a significant opportunity for growth and improvement in our health system. However, we need to be mindful of the fact that change can be difficult. If the changes being proposed here are to provide the benefits we are looking for, implementation of change must proceed through co-operation, partnership, and clear communication.

The Action Plan

Our health plan provides a province-wide human resources strategy to secure the health providers needed. The plan makes an initial investment of $3 million to implement specific initiatives in co-operation with health care providers and employers. Additional funding will be provided to train emergency medical technicians and advanced practice nurses.

TRAIN MORE HEALTH CARE PROVIDERS IN SASKATCHEWAN

- We will add new training seats for the providers most in need. Training seats for both nurses and physicians have been recently increased, and we will continue to monitor the need for additional spaces.
- We will train 240 new or existing ambulance attendants to become emergency medical technicians (EMT-Basic).
- We will train additional advanced practice nurses.
- We will allocate other training spaces, based on priority needs. These will be developed in consultation with educational and other health sector partners.

DEVELOP A REPRESENTATIVE WORKFORCE

- We will build opportunities for full participation by Aboriginal peoples, and strive to recruit Aboriginal candidates into a wide range of health-related occupations.

- We will continue to enhance educational programs available in the North.

- We will continue to invest in cultural awareness training to encourage a supportive and welcoming workplace environment.

TARGET BURSARIES TO FILL VACANCIES

- We will expand bursary programs for other hard-to-fill professions. Bursary programs tied to return-service commitments have proven to be a successful strategy in increasing the number of graduates in medical and other hard-to-recruit professions who stay in Saskatchewan.

- We will offer more bursaries to increase the supply of needed workers and make students feel more valued and appreciated.

EXPAND CONTINUING EDUCATION AND DEVELOPMENT

- We will support professional development for health system workers. Increasing education and training opportunities has a twofold purpose. Not only does continuing education add to the overall skill level, leading to improved services, but professional development also helps retain and attract providers through opportunities to expand responsibilities, and demonstrates that workers are valued and appreciated.

- We will work to improve the skills of health system managers for new forms of service delivery and a positive work environment.

- We will provide team development training so that primary health care providers can all contribute to a patient-centred approach.

IMPROVE JOB SATISFACTION

- We will create workplaces that attract new employees. There are proven strategies to improve workplace morale – ideas that have made some places into "magnet" environments that successfully attract and keep staff.

- We will continue to invest in projects to improve the workplace. Projects to improve communication, decision-making, scheduling and staffing are just a few examples that are being developed and promoted across the province, in co-operation with health care providers.

IMPLEMENT PROVINCE-WIDE HEALTH HUMAN RESOURCES PLANNING

- We will bring planning for human resources needs under strong central direction.

- We will build capacity within government to develop solutions to supply, skill mix, distribution and workplace needs within the health workforce.

- We will keep retention, recruitment and training issues front and centre in consultations and strategy sessions with our partners in health and other sectors.

HEALTH SCIENCES EDUCATION

The future health system requires strong health sciences education to meet the need for health services, academic training and research. New approaches are needed to reflect the priorities of the Saskatchewan health care system, including a focus on primary health care, core specialist services, rural health and Aboriginal populations.

Two major reviews of the College of Medicine and the recent report of the Commission on Medicare have all concluded that the College plays an important role in training physicians, delivering specialized medical services, and leading health research. These reports have also pointed out that the mandate of our academic institutions must reflect the nature and priorities of Saskatchewan health care.

If health care professionals are expected to work together more closely, it makes sense for this teamwork to begin with joint planning and delivery of educational programs. Training programs for physicians, nurses and other providers would benefit from shared approaches and closer integration into health service delivery. Our health plan has as a priority component the development of an integrated Academic Health Sciences Network, with the College of Medicine playing a key role. This network will extend into all health regions, expanding the knowledge of local practitioners and offering students the opportunity to work in rural and urban settings.

The recent partnership agreement between the University of Saskatchewan and the Universities of Alberta and Calgary illustrates how Saskatchewan can build on its strengths and work collaboratively with others. Saskatoon and Calgary hospitals have agreed to provide backup services for each other in times of peak demand. The facilities will also work together in the areas of medical education and research. In a world of highly specialized expertise, this type of collaboration among western provinces will be an important strategy to encourage academic excellence and protect service delivery.

Health research is important to health care, as well as to economic development in Saskatchewan. Medical specialists are attracted to locations with a strong research environment. Provincial government funding for research helps attract additional dollars from outside the province.

For all of these reasons, gradual increases in research investment, and other efforts to strengthen the research base, are part of our plan for health care.

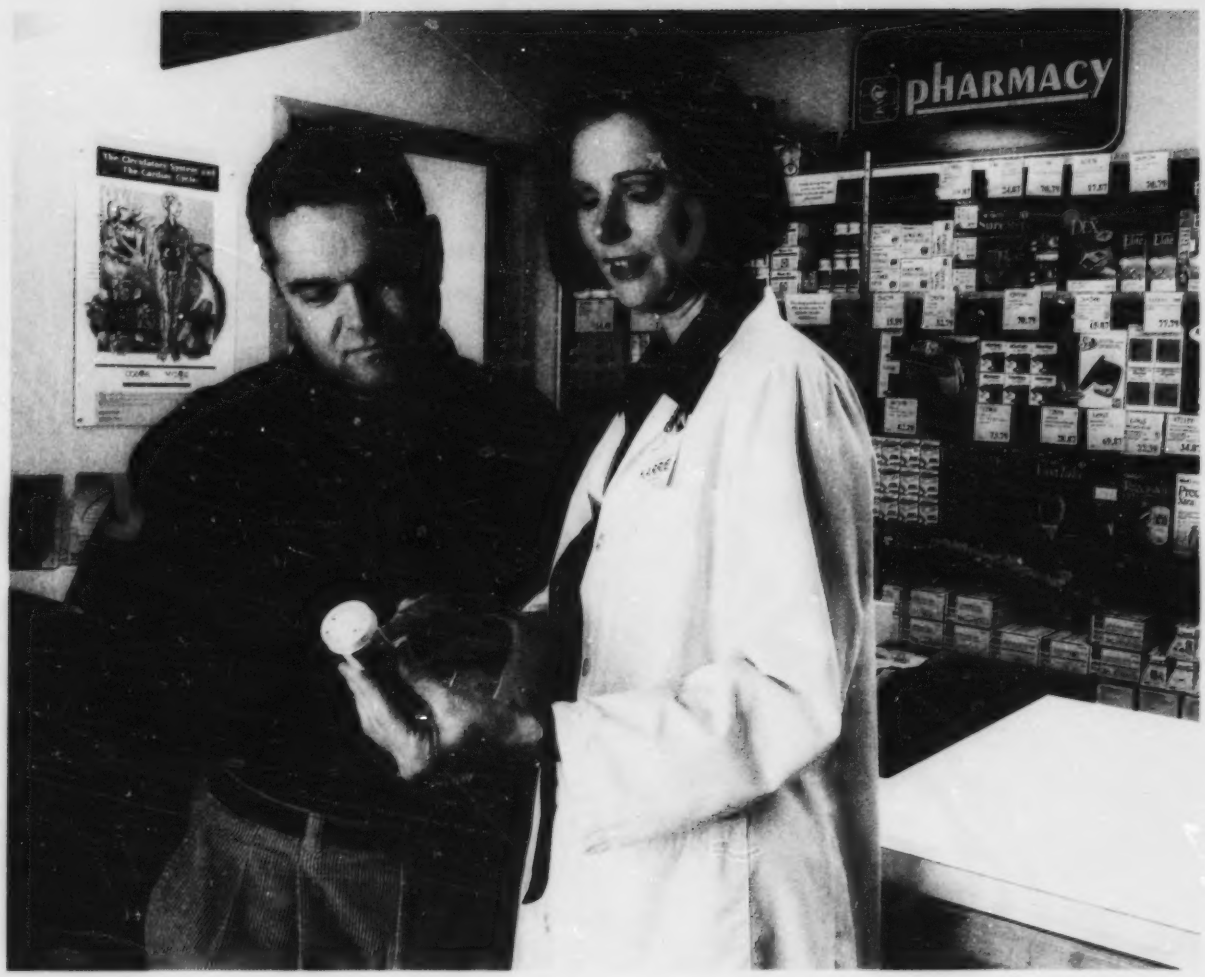
The Action Plan

A COMMITMENT TO HEALTH SCIENCES EDUCATION AND RESEARCH

- We will support bringing health training programs together in an integrated Academic Health Sciences Network.
- We will support the College of Medicine as a key resource in the delivery of health services, in meeting provincial training needs, and in conducting research.
- We will increase the support for health research by 40 per cent in the 2002-03 budget by adding $2 million to the $5 million invested this year, with further increases to follow.

SECURING THE FUTURE

Taken together, our strategies will help make Saskatchewan an attractive place for health care professionals and contribute to the long-range sustainability of our health workforce.



The Plan For Quality Care

Our health plan includes a commitment to quality. We will establish Canada's first health care Quality Council, reporting to the Minister of Health.

The Council will be led by experts in health services delivery and quality improvement, and will be a resource to government and the health care professions. The Council will provide advice on the requirements for a high quality of care, collect and disseminate evidence on best practices, and evaluate new technology, drugs and other clinical developments. The Council will promote innovative ideas to encourage excellence throughout the health system, and will also report to the public on the quality of health care.

ACHIEVING MAXIMUM VALUE

Health care is considered by many people to be the most important service funded by government. The Province of Saskatchewan spends more taxpayers' money on health care than on any other program area. Still, it is difficult to answer the question "Are we getting the best value for the resources we spend on health?" We can itemize all the services that our money buys, but it is much more difficult to know what the "right level" of services should be, and whether we are investing wisely.

Quality in the health system is the responsibility of many people. Health professionals themselves are responsible for the quality of the services they provide. Health system managers and boards are also responsible for quality. Ultimately, the Minister of Health is responsible for ensuring a quality system overall.

Ideally, judgments about quality should be based on sound evidence that the programs, practices and procedures within our health system are the most effective means to improve the health of individuals and society. However, evidence that is generated by studies and analysis is not always sufficient, and it may not be easily available or understood. Even when evidence is available, it may not be adequately used in making the thousands of daily decisions that shape the health care system.

UNDERSTANDING QUALITY

When asked, the majority of Saskatchewan residents rate the quality of health care they have received as good or excellent. Individual satisfaction is important, but satisfaction alone does not tell us whether the treatment was appropriate, effective and safe.

Health care providers have expressed concern that health care quality is compromised by a lack of adequately trained staff, excessive workloads and long waiting times for some services. Yet we do not have widely accepted ways to measure the extent of these problems, or to tell if they are getting better or worse.

EXISTING APPROACHES TO QUALITY

Professional Self-Regulation

Health services are delivered by a wide array of self-regulated professions that ensure standards for education and training. Professional associations may discipline individual members who fail to live up to the standards and ethics of the profession. These associations cannot address problems in the way the system works.

Legislated Standards

Legislation is used to enforce standards of care. The trend in some cases is to move away from specific regulations in favour of service agreements and guidelines that are more flexible in a fast-changing environment.

Health Plans

District health boards are responsible for assessing the health care needs of residents, planning the delivery of health services and evaluating results. Regional Health Authorities must continue to be held accountable, and their efforts will be more effective through the support of a Quality Council.

Performance Monitoring & Measurement
Initiatives of provincial and federal governments, the Cochrane Collaboration, and the Canadian Institute for Health Information, are among efforts to measure the quality of health services and the health status of populations. Reporting to the public is a high priority. In September 2000, the federal and provincial governments made a commitment to comprehensive and regular reporting on the health services they deliver.

Health System Research
Saskatchewan Health, the Health Services Utilization and Research Commission (HSURC), and others routinely undertake research and surveys designed to provide the information necessary for quality health care. Since its establishment in 1992, HSURC has, for example, developed clinical practice and other service guidelines (e.g. use of routine admission tests and use of day surgery) which have led to more appropriate use of health services.

Clearly, no single yardstick can be used to measure the quality of our health system. Quality in health care is complex. Quality can be compromised by providing too much service, too little service, or the wrong service.

Errors in health care may generate media attention. We may see news accounts of a patient who was administered a lethal dose of the wrong drug, or a patient who was injured as a result of a surgical error. Concerns about too much service are not heard as often. However, harm is also done when antibiotics are prescribed unnecessarily, or when x-ray or other diagnostic tests are overused.

Unnecessary use of services adds to the cost of an already overburdened health system and subjects patients to potential harm. On the other hand, failure to provide enough service, or delays in service that is needed, are also concerns since they may result in complications, higher costs and harm to health.

MEASURING PERFORMANCE

Health care systems have a lot to learn from agencies like the National Aeronautics and Space Administration in the United States when it comes to quality control. Space travel and health care both require consistently high quality because the services they deliver are complex. It is not enough to observe the space shuttle making a successful liftoff or a patient surviving a surgical procedure. Rather, it is vital that each step of the process takes place within acceptable limits, because failure at any step can cause a failed outcome.

Performance monitoring and measurement are key elements of a service cycle that includes:

- identifying the needs and priorities of Saskatchewan residents;
- organizing resources (including financial and human resources) to address those needs;
- delivering the required services; and
- measuring the results of services and making needed improvements.

Until now, our efforts have been largely focused on organizing and delivering services. Much more needs to be done to identify priorities and measure results. Saskatchewan citizens have a right to know how their health system measures up. The Quality Council, building on initiatives already in place, will vastly increase our ability to understand, and improve, health system quality.

The Action Plan

Our health plan supports the idea of a Quality Council as a vehicle to achieve health care excellence.

CREATE A QUALITY COUNCIL

- We will move quickly to bring the concept of a Quality Council into reality.
- An expert board will govern the Council's activities and report to the Minister of Health.
- Individuals appointed to the board will be chosen for their knowledge and expertise, and not for their affiliation with any specific organization.
- Board membership will include recognized experts from both within and outside the province.

SUPPORT DECISIONS WITH EVIDENCE

The Quality Council will:

- advise government on the population, service volume and infrastructure required (clinical standards) to deliver high quality services;
- evaluate new technology, drugs and other clinical developments, including value-for-money assessment;
- promote effective practices to professionals across the province;
- monitor and assess the performance of the health system; and
- inform the public about the quality of health services in Saskatchewan.

To avoid duplication of effort, some functions of HSURC will be rolled into the Quality Council.

Initial costs of the Council will be about $5 million per year, including a transfer of $1.3 million currently going to HSURC.

CLOSING THE QUALITY GAP

The Quality Council will have the capacity, expertise and breadth to identify the gap between "what is" and "what should be." It will develop evidence-based approaches, and promote effective practices throughout the system. It will also give citizens the information they need to assess the quality of our health care services.

The Plan For Regional Health Authorities

Our health plan will improve province-wide health system co-ordination by merging 32 health districts into 12 Regional Health Authorities (RHAs). The Athabasca Health Authority and the two northern districts will retain their current boundaries. The remaining 30 districts will be combined to create 10 Regional Health Authorities based on existing service area boundaries.

The 12 new Regional Health Authorities will work closely with the provincial government on long-term planning and co-ordination of services. Authorities will be governed by boards appointed by the Minister of Health, and will operate under clear service agreements. Citizens throughout each region will also be linked to the work of the Regional Health Authorities through Community Advisory Networks.

GETTING REGIONS RIGHT

In 1993, Saskatchewan was one of the first provinces in Canada to implement a regional model of health care. More than 400 boards, each responsible for a single hospital, nursing home, or home care service area, were replaced by 32 health district boards and one health authority responsible for a much wider range of services. Over the years, Saskatchewan's health districts have done an excellent job of breaking down barriers between different types of services, so that the full range of health care is better co-ordinated around people's needs.

Many existing boards, however, are too small to effectively offer a full range of services to their residents. The large number of districts makes it difficult to co-ordinate and plan services across the whole province. Most other provinces, even those with larger populations, have far fewer districts than Saskatchewan's 32. Alberta has 17 health authorities and Manitoba has 12.

REDUCED ADMINISTRATION

Combining 32 districts into 12 will help to reduce duplication and lead to more efficient management. It will also bring together a critical mass of the skills needed to plan and deliver health services. Larger Regional Health Authorities will be better able to recruit health care providers, and will have the capacity to offer a full range of primary health care services. They will also be able to take on the work necessary to strengthen our hospital, emergency, and long-term care systems.

ADVANTAGES OF NEW, LARGER REGIONAL HEALTH AUTHORITIES:

- reduced duplication, more efficient administration;
- wider range of services in each region;
- ability to recruit and retain health care providers and management teams;
- improved planning and co-ordination among regions; and
- local involvement through Community Advisory Networks.

In 1995, Saskatchewan implemented a process to select district health board members through a combination of elections and appointments. This system has been costly and not very popular. With few candidates coming forward for elected positions, and poor voter turnout, board elections have not proven to be an effective way to involve the public.

The new Regional Health Authority boards will be appointed by the Minister of Health to represent a cross-section of the community and bring a mix of expertise and viewpoints to the table. Appointments will be made from names put forward in a public nomination process.

DISTRICT HEALTH BOARD ELECTIONS 1995-1999

	Acclaimed candidates (no election due to lack of candidates)	Voter turnout	District election costs
1995	30% (69/232)	33%	$771,351
1997	68% (85/125)	25% *	$394,703
1999	65% (82/127)	10%	$391,825

* 1997 elections were held in conjunction with elections for urban municipalities and school divisions.

Regional Health Authority boards will oversee changes to the health delivery system outlined in this plan. Following a period of establishment of Regional Health Authorities, we will consider options for re-establishing boards comprised of elected and appointed members.

REDESIGNED BOUNDARIES

The current district boundaries were developed based on local and regional preference, with the only limiting factor being a minimum population size. In many cases these boundaries do not reflect actual service or market patterns, so people must often go outside their district to receive services.

Service patterns are influenced by a number of factors, including highways and the referral relationships of physicians. Based on a review of patient flow patterns, the boundaries in our health plan are different from those proposed by the Commission on Medicare. The new boundaries are designed to reflect existing service relationships so that the need to travel outside a Regional Health Authority for service is minimized.

Community and regional hospitals that already serve many of the same clients will be able to work together more effectively under the leadership of the same Regional Health Authority. The new authorities will incorporate existing boundary lines, which will help to minimize disruption during the transition.

If experience shows that adjustments to the boundaries are required, we will work with Regional Health Authority boards and the public on refinements.

COMMUNITY INVOLVEMENT

Developing health services that respond to public needs requires community involvement. As the Commission on Medicare pointed out, however, larger districts may be just as effective at involving the community as smaller ones – perhaps more so. Regional Health Authorities will establish Community Advisory Networks to ensure that boards benefit from local involvement when setting directions for health care. Effective links will be maintained with community leaders, consumer groups, and education and social agencies so that citizens have many opportunities to be heard.

EFFECTIVE PROVINCE-WIDE PLANNING

Planning in the health system has been hampered by the difficulty of co-ordinating a large number of districts. Plans within any one district affect the surrounding area and, often, the whole province. The co-ordination that is needed to prevent gaps in services takes time and energy when there are 32 districts.

With a smaller number of authorities, we will be able to implement better structures for province-wide planning. The role of the Minister of Health in setting overall priorities for the health system will be strengthened and clarified. This will mean stronger central direction of human resources planning, program development, and capital projects.

Planning has also been hampered by single-year funding plans resulting from provincial budget timeframes. Funding decisions announced shortly before the fiscal year begins force plans to be delayed well into the budget year. One result has been deficit spending by districts, which contributes to the escalating costs of health care.

Once Regional Health Authorities are established, we will enter into agreements that include longer-term funding commitments. Planning will be more effective, and authorities will be more accountable for financial management.

STRONGER PARTNERSHIPS

Over the years, there have been stresses and strains in the partnership between district health boards and government because responsibilities have not been clearly understood. The Saskatchewan Association of Health Organizations (SAHO) has repeatedly called for clarification of the roles of districts and government.

What we need is a more workable set of rules and division of authority. Under the new system, the roles and responsibilities of each partner will be clearly defined, and there will be a stronger role for Saskatchewan Health in the overall planning and direction of province-wide health care.

"....today, the division of responsibilities between health districts and the provincial government is by no means clear... [and] the planning process is ineffective:

- *districts often plan in isolation from one another;*
- *districts compete with each other for scarce human resources; and,*
- *decisions to close operating rooms or intensive care units made by one district can adversely affect surrounding districts."*

Commission on Medicare Report

IMPLICATIONS OF CHANGE

We do not take lightly the implications of a change from districts to Regional Health Authorities. Such a move will inevitably cause disruption and anxiety, and will have implications for many organizations and individuals.

Employees of health districts can be assured that their skills and abilities are valued and will continue to be needed as the new system evolves. Effecting a smooth transition will require the patience and co-operation of all concerned.

PLANNING THE TRANSITION

New authorities must be put in place without delay so that they can focus on the important work of improving hospital and emergency services and developing primary health services networks.

To effect a smooth transition to the new system, the new boards will be established as planning committees effective early in 2002. These committees will be named as the new Regional Health Authority boards through legislation that will be introduced in the Spring legislative session. At least six of the 12 board members will be chosen from the existing health district boards that make up the new region, with a minimum of one member being selected from each of the current district boards.

To minimize disruption, the new regions will be defined along existing health district boundaries. This will mean that the transition can take place more quickly, that contracts and obligations will be transferred to the new Regional Health Authorities, and that the effect on all employees in a district will be consistent.

We will not initiate change in union affiliation of employees.

The Action Plan

Our health plan includes a more logical configuration of regional authorities, a clear set of responsibilities, and a better process for planning.

ESTABLISH NEW REGIONAL HEALTH AUTHORITIES

- We will consolidate 32 health districts into 12 Regional Health Authorities. (RHA boundaries are shown in the map on page 63.)
- We will reduce duplication and costs, while ensuring regions are large enough to co-ordinate most of the services their residents need.
- We will appoint 12-member Regional Health Authority boards comprised of community leaders. Initial appointments will include members of existing district boards. Appointments will be made from names put forward in a public nomination process. To avoid conflicts of interest, Regional Health Authority employees or those with a significant contractual relationship to the organization will not be eligible for appointment.
- We will establish Community Advisory Networks that ensure public involvement and communication links across each region.

IMPROVE LONG-RANGE PLANNING

- We will work together with Regional Health Authorities to ensure co-ordinated province-wide planning.
- Once established, Regional Health Authorities will receive longer-term funding commitments and will be clearly accountable for financial management.
- Health plans will be developed within a framework of common objectives, and approved by the Minister of Health prior to the start of the fiscal year, starting in 2003.

DEVELOP CLEAR ROLES AND RESPONSIBILITIES

- The authority of the Minster of Health to set priorities for the health system will be clarified and strengthened.
- Enhanced service agreements will define the responsibilities of Regional Health Authorities to organize, manage and deliver health services.

EFFECTIVE AND EFFICIENT GOVERNANCE

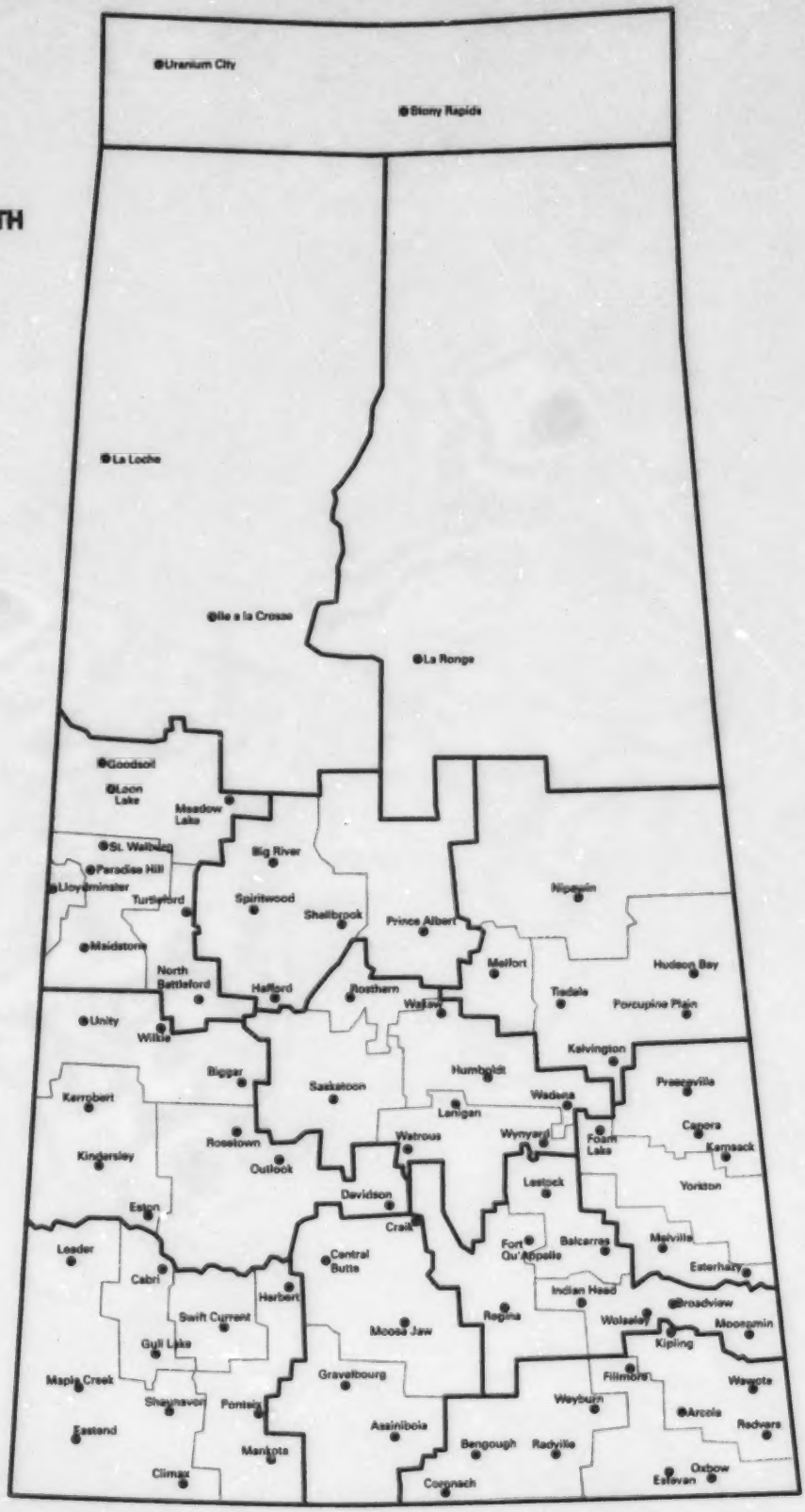
A new system of Regional Health Authorities will build on the strengths of the health district process, while incorporating the lessons learned over the years.

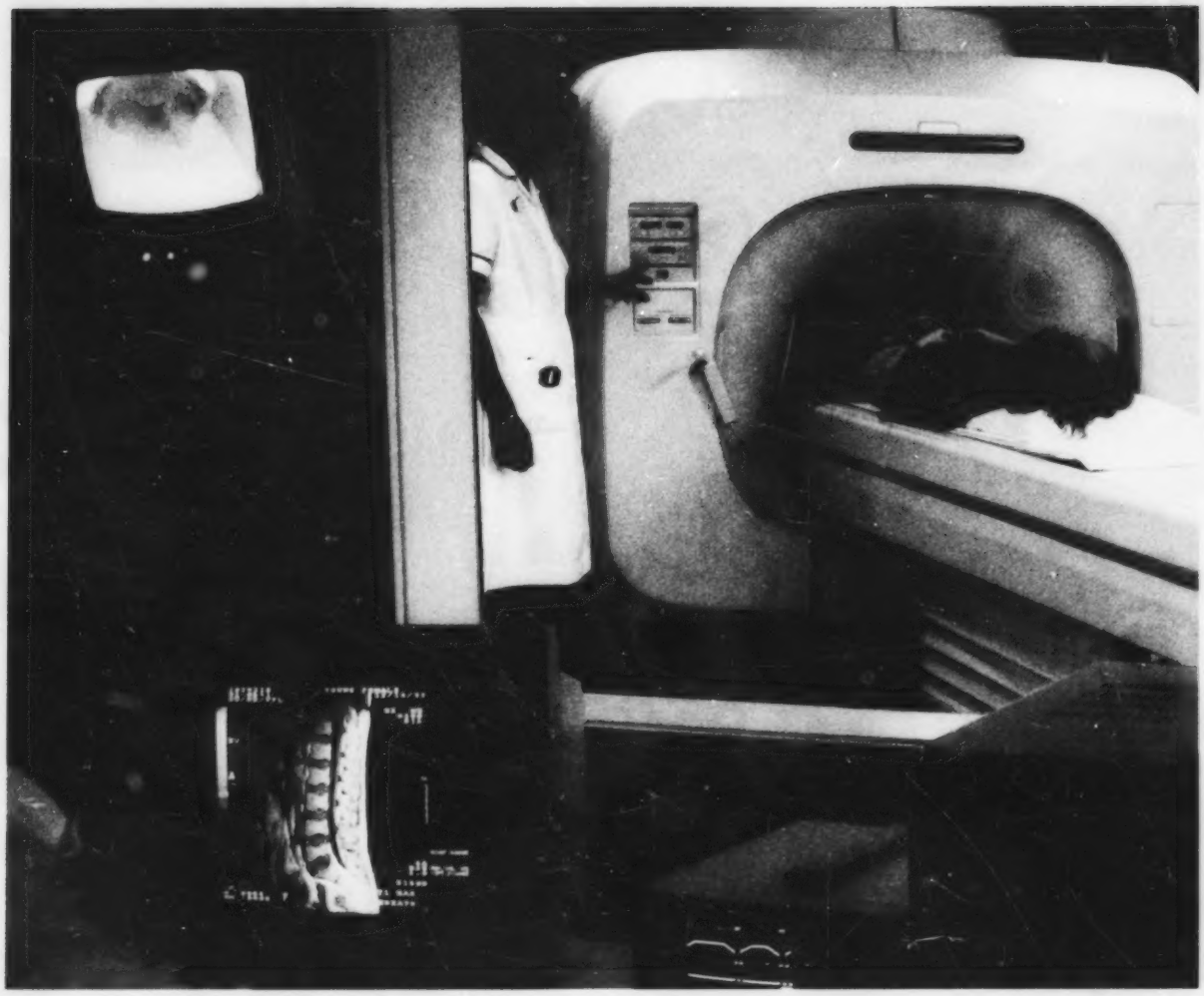
As a result, government, health care providers and the public will all have a better idea of what to expect from their health care system.

REGIONAL HEALTH AUTHORITY BOUNDARIES

Health District Boundaries

New Regional Health Authority Boundaries





The Plan To Sustain Public Medicare

Saskatchewan residents agree that accessible quality health care is the top priority of government. Our commitment to the ideals of publicly funded Medicare continues. Not only is publicly funded health care proven to be the most cost-effective model, it is also the best way to make health care equally available to all. There remain, however, concerns about our ability to pay for the health system we want.

Our health plan will set Saskatchewan on the road to a more efficient, more affordable health care system. In addition, we must work with other provinces and the federal government to ensure the resources are in place to maintain a strong publicly funded health system across Canada.

THE SUSTAINABILITY CHALLENGE

Health care spending has gone up dramatically over the years, and there are always demands to do, and spend, more. Some say that Saskatchewan's health care needs more cash – for higher wages, shorter waiting times, and new technologies. Others, including the Commission on Medicare, say that we should resist demands to spend more until we are sure that we are getting quality and value for money – putting our money where it does the most good. Rising health care spending, the Commission pointed out, threatens to squeeze out improvements to education, housing and economic development—all of which contribute to a healthier population.

Many people are puzzled why spending on health keeps going up, and yet waiting lists and other problems continue. It is useful to have a look at health care spending, how Saskatchewan compares to other places, and what factors contribute to growing costs.

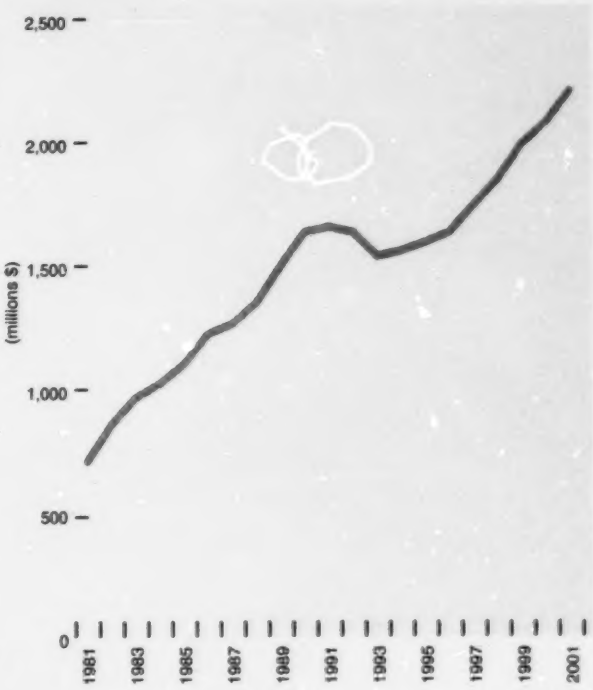
HEALTH SPENDING IN SASKATCHEWAN

Government health spending in Saskatchewan is mid-range among the provinces. In 2000, Saskatchewan ranked fifth out of 10 provinces in spending per capita at $2031 per person, slightly above the national average of $2017. For the year 2000, the Canadian Institute for Health Information (CIHI) forecasted that Saskatchewan's health care spending would be 6.5 per cent of the province's total economic output (GDP). This is slightly above the average 6 per cent of GDP for all provinces.

Between 1981 and 1990 provincial government health spending in Saskatchewan increased by an average of 9.7 per cent per year, growing to 8 per cent of GDP. In the years from 1991 to 1997, spending growth was held to an average of 0.9 per cent per year, and fell to 6 per cent of GDP. How was this change accomplished?

A number of measures to improve efficiency and quality of service played a part in this change. For example, hospital beds were reduced by 52 per cent. At the same time, new surgical techniques permitted shorter hospital stays, and the number of surgical procedures actually increased while bed numbers declined.

SASKATCHEWAN HEALTH SPENDING



Source: Saskatchewan Health

In a similar fashion, increased home care services allowed for a reduction of special care home beds, along with a reduction in nursing home waiting lists. These changes were difficult and occasionally unpopular. However, the changes did help to limit cost growth, and research shows that patient health and treatment outcomes were not negatively affected.

While measures like these were successful in moderating the rate of spending for a time, since 1998 health spending has again been rising as both a proportion of the economy (GDP) and as a proportion of government spending. Policy and system changes can result in savings, but experience shows us that there are underlying factors inherent in health care that continue to push up costs.

WHAT DRIVES UP COSTS?

Costs of health care tend to rise faster than other parts of the economy. In addition to overall inflation, health care costs go up due to rising wages and fees and population shifts. Alongside these trends, the expansion of medical knowledge itself – bringing with it new technologies, new treatments, and new drugs – creates relentless cost pressures.

LABOUR COSTS AND MEDICAL FEES

Over two thirds – 67 per cent – of government health spending goes directly to pay health workers and professionals through wages and fees. Rising demand and projected shortages of personnel have contributed to wages in the health sector that have grown faster in recent years than other wages. Over the longer term, educational standards increase as medical knowledge becomes more complex, and this factor contributes to wage growth as well.

POPULATION SHIFTS

In Saskatchewan our population numbers are stable overall, but the composition is changing. We have more elderly people and young children as a proportion of the total population. As well, the proportion of citizens who are of Aboriginal ancestry is growing, and studies show that these groups have more health needs than the population as a whole.

VOLUME GROWTH

Per capita use of health services also goes up, year over year. The number of tests, prescriptions and services grows independent of other factors. The reasons for this are not entirely clear, but they may relate to standards of care going up. For instance, a physical assessment may be supplemented by a lab test that becomes available and is adopted into medical practice.

EXPANDING KNOWLEDGE AND STANDARDS OF CARE

As health care knowledge grows, new conditions are identified, and new tests, treatments and drugs appear. Consider how many of the conditions we read about today were unknown a few years go. Procedures such as bypass surgery or hip replacement, that once were rare, are now almost commonplace. There are more techniques and treatments available for conditions that used to be unknown or untreatable. Many of these advances contribute to our health and well-being, but they may also make the health system more expensive for all of us.

NEW DRUGS AND TECHNOLOGIES

New technologies have the potential to both raise and lower costs. Investment in some technologies (e.g. laproscopic surgery) may enable the system to deliver better health services at a lower cost. Some new drugs may help people avoid expensive hospital care. In other cases, new techniques and new drugs can be vastly more

costly than older ones, though they may deliver only slightly better results.

THE GROWING COST GAP

Cost growth in itself is not necessarily a problem. If improvements in care cost more, that represents an improved standard of living. If the provincial economy – and our incomes – grow as well, then we can afford to pay for these improvements. The difficulty arises when health care growth outpaces economic growth overall. When health costs grow at 6 to 8 per cent and the economy grows at 3 per cent, it takes a higher and higher share of our collective wealth just to keep even. At that point, health care costs may be considered unsustainable.

The Action Plan

Our health plan provides a blueprint for a more effective, better managed and higher quality health system. Our plan makes new investments, without service reductions, fee increases or other measures to reduce short-term costs. Our health plan also contains measures that will help keep costs more affordable in the long-term.

USE ALL SKILLS EFFECTIVELY

The plan for primary health care will make the best possible use of the skills of all health care providers. If our health system can employ nurses, nutritionists and mental health workers to the fullest, we can limit demands on the time of physicians. If we employ primary care physicians to the fullest, we can limit demands on the time of medical specialists. As the Saskatchewan Health Information Network (SHIN) develops and allows information to be shared effectively among health providers, it will reduce duplication of appointments and tests. All of these things will help make our system more cost-effective.

Most importantly, effective primary health services can help prevent illness or control conditions before they get serious, reducing costs by limiting the need for more expensive treatments.

ENSURE EVIDENCE-BASED QUALITY

The Quality Council will set a new direction toward a quality, cost-effective, results-oriented health system. The overall goal of the Council will be to ensure the best quality care possible – to get the most from our public investment.

Good information is the key to quality improvement in any industry. When we do not know for sure whether the most expensive drug is actually the best, that can add to costs. If we do not know for sure whether two tests will yield more accurate results than one – the temptation is to order two. The Quality Council will give government, physicians, and other health care providers the tools they need to make decisions based on evidence, and to deliver the best possible care.

ENSURE COST-EFFECTIVE SERVICES

The plan for Regional Health Authorities will contribute to a more cost-effective health system by reducing duplication in administration, and by improving co-ordination and planning.

A smaller number of Regional Health Authorities will bring economies of scale. They will be better able to gain

efficiencies through joint initiatives from software development to planned capital purchases and quantity buying. New relationships between the government and the Regional Health Authorities will mean better financial planning and tighter spending controls.

Hospital services are the most costly part of our health system. The clear classification of hospitals, and the development of hospital networks outlined in this plan will mean more efficient delivery of hospital services. Duplication of services will be reduced, with hospitals sharing resources and working together co-operatively to provide services. All hospitals will have a defined level of services, allowing each facility to concentrate on what it does best.

MEETING THE FINANCIAL CHALLENGE

Our health plan outlines changes that will enhance quality and help make health care more affordable. Beyond our efforts, health providers also share the responsibility of using resources wisely, and Saskatchewan people, too, can help reduce costs by using the system wisely. We have choices to make, such as using hospital emergency rooms and ambulances only when necessary. We must recognize that Medicare is not intended to take the place of the care and support that we provide to each other as families and community volunteers.

The health system that will grow from this plan reflects our values – we want to ensure fair access to quality health services for everyone. Our research also shows that the publicly financed, publicly administered health system remains the most cost-effective option for sustainable health care in Saskatchewan.

While our health plan establishes Saskatchewan at the forefront in creating a more efficient, more affordable health care system, the issue of affordability cannot be set aside. Today, we are spending more on health care in Saskatchewan than is collected through personal income taxes and the provincial sales tax. The fundamental trends that cause health care costs to grow year after year remain. Paying for the health care system we want and need will continue to be a challenge for the future.

All provincial governments have concerns about sources of health care funding. We must work with all our partners in the health sector to implement cost-effective approaches to health care delivery. We must also work with the federal government to ensure that there is adequate funding to protect Medicare for all Canadians.

Appendices

Appendix I

HOSPITAL CLASSIFICATION SYSTEM

	Community and Northern	District
CORE SERVICES	• 24 hours per day/7 days per week coverage (24/7) in general medicine and emergency stabilization. • Low-complexity surgeries and low-risk obstetrical services will also be offered at designated sites.	• 24/7 coverage in general medicine and emergency stabilization. • Low-complexity surgeries and low-risk obstetrical services at all sites.
EMERGENCY	• 24/7 physician on-call. • Initial assessment and triage of all outpatients. • Stabilization and transfer to appropriate expanded emergency services. • Thrombolytic therapy.	• 24/7 physician on-call. • Initial assessment and triage of all outpatients. • Stabilization and transfer to appropriate expanded emergency services. • Thrombolytic therapy.
DIAGNOSTIC	• 24/7 basic radiography and laboratory services available. • Saskatchewan lab licensing category 4 laboratory. Category 5 laboratory at designated sites.	• 24/7 basic radiography and laboratory services available. • Category 5 laboratory.
MEDICINE	• 24/7 acute care – stable medical conditions. • 24 hour observation and assessment, convalescent care, and palliative care.	• 24/7 acute care – stable medical conditions. • 24 hour observation and assessment, convalescent care, and palliative care.
ICU/CCU	• No intensive care unit (ICU)/coronary care unit (CCU).	• Constant observation beds at designated sites.
SURGERY	• General outpatient surgeries with local anesthesia. • Surgical privileges as defined by the College of Physicians and Surgeons of Saskatchewan with consideration of clinical supports available.	• Surgical privileges as defined by the College of Physicians and Surgeons of Saskatchewan with consideration of clinical supports available.
ANESTHESIA	• Local anesthesia. • Family physicians with additional training as defined by the College of Physicians and Surgeons of Saskatchewan at designated sites that perform procedures requiring more than local anesthesia.	• Family physicians with additional training as defined by the College of Physicians and Surgeons of Saskatchewan.
OBSTETRICS	• Emergency obstetrical services. • Low-risk deliveries with appropriate back-up at designated sites.	• Emergency obstetrical services. • Low-risk deliveries with appropriate back up.
PEDIATRICS	• Observation and assessment.	• Observation and assessment. • Stable pediatric medical conditions.
PHYSICIAN STAFFING GOAL	• Minimum 1 family physician on staff linked into group practice consisting of 3 family physicians. 3 or more family physicians on staff at larger facilities.	• 5 to 7 resident family physicians plus family physicians with additional training in anesthesia and surgery.
NURSING STAFFING	• 24 hour on-site registered nursing (RN) coverage.	• RN staffing may include a mix of basic and advanced skills and training.

Appendix I

HOSPITAL CLASSIFICATION SYSTEM

	Regional Subdivided into 2 Groups - Level 1, Level 2	Provincial
CORE SERVICES	• Services at District Hospitals plus core specialty services (internal medicine, general surgery, obstetrics, and gynecology).	• Services at Regional Hospitals plus subspecialty services. • Some services may be offered from 1 designated site within a city. • Highly specialized services may be offered from 1 designated site within the province, or in neighbouring provinces.
EMERGENCY	• Services at District Hospitals plus: • Range and complexity of care appropriate to diagnostic and critical care supports available.	• Services at Regional Hospitals plus: • 24/7 emergency room physician. • Full trauma services.
DIAGNOSTIC	• Services at District Hospitals plus: • Fluoroscopy • Additional diagnostic imaging capabilities at designated sites. • Category 6 laboratory.	• Services at Regional Hospitals plus: • Interventional radiology, magnetic resonance imaging (MRI), nuclear medicine, hemodynamic laboratory services.
MEDICINE	• Services at District Hospitals plus: • Internal medicine.	• These hospitals will offer the broadest range of specialist services in the province including cardiology, neurology, and nephrology among others.
ICU/CCU	• Services at District Hospitals plus: • Intensive care unit. • 24/7 physician on-call assigned to unit.	• Services at Regional Hospitals plus: • Full critical care response. • 24/7 physician on-site assigned to unit(s).
SURGERY	• General surgical procedures as determined by clinical supports available (e.g. anesthesia, pathology). • Designated sites may provide services in the following areas after core programs fully functional: orthopedics, ophthalmology, urology, and otolaryngology.	• These hospitals will offer surgical procedures of higher complexity across all disciplines. • Specialist coverage in: orthopedics, ophthalmology, urology, otolaryngology, neurosurgery, plastic, cardiac, vascular, thoracic, and oral surgery.
ANESTHESIA	• Specialist anesthetists and family physician with additional training as defined by the College of Physicians and Surgeons of Saskatchewan.	• Specialist anesthetists.
OBSTETRICS	• Obstetrical services including planned and emergency cesarean sections.	• Services at Regional Hospitals plus: • High-risk deliveries. • Neo-natal intensive care unit (NICU).
PEDIATRICS	• Services at District Hospitals plus: • More complex case management in sites with pediatricians.	• Services at Regional Hospitals plus: • Pediatric surgery. • Pediatric subspecialists. • Pediatric intensive care unit (PICU).
PHYSICIAN STAFFING GOAL	• 3 specialists (certified or family physician with additional training) in core specialty areas.	• 3 physicians in each specialty area. • 24/7 on-site or on-call coverage in select subspecialty areas.
NURSING STAFFING	• Nurses covering ICU and other specialized units must have education and qualifications appropriate to services provided at a regional facility.	• Nurses covering ICU and other specialized units must have education and qualifications appropriate to services provided at a provincial facility.

SUMMARY OF KEY INITIATIVES

The Plan for Primary Health Care

- Establish primary health care networks in all of the Regional Health Authorities. Each network will consist of one or more teams providing a full range of primary health care services. Family doctors will join the primary health care teams on a voluntary basis.
- Establish a 24-hour health advice line to support the primary health care networks.
- Improve health information systems to give health care providers the information they need to better co-ordinate and improve patient care.

The Plan to Promote Healthy Communities

- Develop a provincial population health promotion strategy identifying the top priority areas for health promotion and disease prevention initiatives.
- Work with Regional Health Authorities, health groups, the business community, municipal government, human service agencies and other partners in education and social services on the provincial population health promotion strategy.
- Implement better measurement and public reporting of health status.
- Through the expansion of primary health care teams, take a more proactive approach to the prevention of illness and injury.

The Plan for Northern and Aboriginal Health

- Support the development of a Northern Health Strategy in partnership with the northern health authorities and the Northern Inter-Tribal Health Authority, based upon previously identified health goals and objectives.
- Support northern hospitals in La Ronge, Ile a la Crosse, La Loche and Stony Rapids, where the new Athabasca Health Facility is under construction.
- Expand primary health care services in Aboriginal communities, in partnership with the federal government, First Nations and Metis people.
- Work with the Colleges of Medicine and Nursing, as well as other health disciplines to give greater priority to Aboriginal health issues.
- Encourage greater Aboriginal participation in health workplaces.

The Plan for Better Emergency Medical Care

- Train 240 new or existing ambulance attendants up to the EMT-Basic level over a three-year period.
- Improve emergency response times, as resources allow, in areas where the need is greatest.
- Improve the dispatch of ambulance services by co-ordinating all ambulance calls through the province's five wide-area dispatch centres.
- Introduce provincial regulations for road ambulance fees to ensure greater consistency across the province. As resources allow, move to lower the cost of inter-hospital transfers.

The Plan for Better Hospital Care and Long-Term Care

- Establish new hospital categories that set out a clear structure for hospitals, so the public and health providers know which services are available in each facility.
- Support community hospitals in communities with populations of less than 3,500. These hospitals will focus on emergency services and general medicine.

- Support for nothern hospitals including the new facility in Stony Rapids, which is currently under construction.
- Support regional hospitals in six communities and district hospitals in nine communities. These hospitals will focus on emergency services, general medicine and select specialty services as volumes and resources permit.
- Provide stable funding for the five major provincial hospitals in Regina and Saskatoon. These hospitals will provide a broad range of services, from basic to highly specialized.
- Give seniors and people with disabilities more options to remain independent by allowing the development of more personal care homes, providing support to more seniors living in social housing and providing an individualized funding option.

The Plan to Reduce Waiting Times

- Increase funding to surgical centres to support health provider salaries, medical and surgical equipment purchases and all essential elements in delivering stable volumes of surgery.
- Improve surgical capacity by keeping and attracting the key health care providers needed to support the delivery of surgery.
- Create a province-wide surgical waiting list to track and assign rankings to all patients needing surgery in the province.
- Improve fairness among patients by developing province-wide guidelines to ensure patients are assigned priority for surgery based on need.
- Provide the public with key contact people and better information on how the surgical booking procedure works, and how long people can expect to wait for certain procedures.

The Plan to Retain, Recruit and Train Health Care Providers

- Train more health care providers in Saskatchewan by adding new training seats.
- Expand bursary programs for other hard-to-fill professions to increase the supply of needed workers and make students feel more valued and appreciated.
- Support continuing education and professional development opportunities for our health system workers.
- Build opportunities for full participation by Aboriginal peoples, and strive to recruit Aboriginal candidates into a wide range of health-related occupations.
- Increase job satisfaction using proven strategies to improve the workplace. In co-operation with health care providers, support projects to improve communication, decision making, scheduling and staffing.
- Implement province-wide health human resources planning to allow for better co-ordination of retention, recruitment and training strategies.
- Bring health training programs together in an integrated Academic Health Sciences Network.
- Support the College of Medicine as a key resource in the delivery of health services, in meeting provincial training needs, and in conducting research.
- Increase support for health research by 40 per cent in the 2002-03 budget by adding $2 million to the $5 million invested this year, with further increases to follow.

The Plan for Quality Care

- Establish and fund a Quality Council to encourage excellence throughout the health care system and report to the public on the quality of care. The Quality Council will provide advice on requirements for high quality service, evaluate new technology, drugs and other clinical developments, and promote effective practices to professionals.

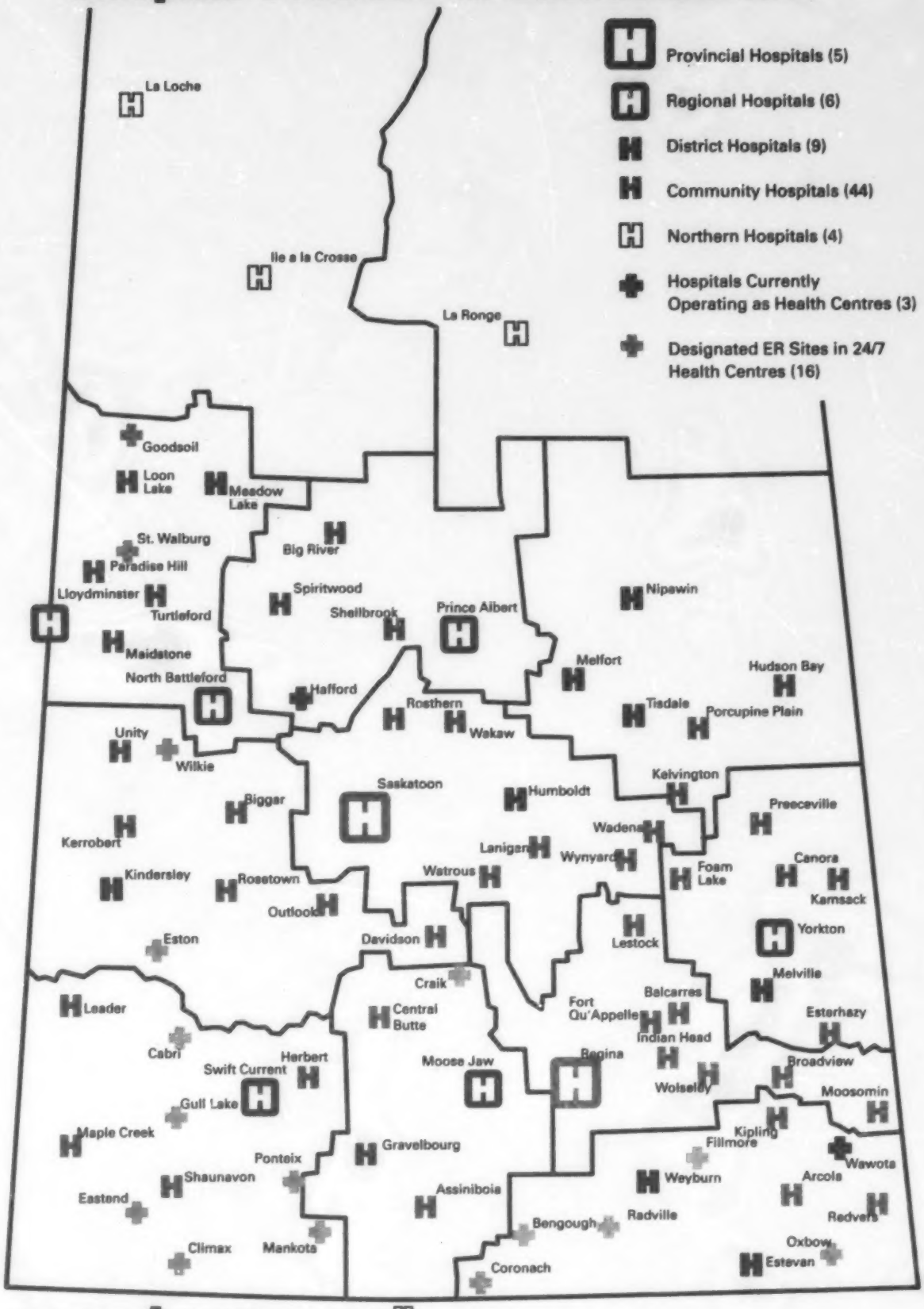
The Plan for Regional Health Authorities

- Establish 12 new Regional Health Authorities by consolidating the existing 32 health districts.
- Boards to be appointed from names submitted in a public nomination process.
- Establish Community Advisory Networks to ensure public involvement and communication links across each region.
- Work with Regional Health Authorities to improve long-range planning. Provide Regional Health Authorities, once established, with longer-term funding commitments and approve health plans before the start of the fiscal year.
- Clarify and strengthen the authority of the Minister of Health to set priorities for the health system. Define the responsibilities of Regional Health Authorities to organize, manage and deliver health services.

The Plan to Sustain Public Medicare

- Support publicly funded Medicare as the fairest and most cost-effective way of delivering health care.
- Make the best possible use of the skills of all health providers.
- Use effective primary health care services to help prevent illness or control conditions before they become more serious and require more expensive treatments.
- Reduce duplication in administration and improve co-ordination and planning by replacing 32 health districts with 12 Regional Health Authorities.
- Create more efficient delivery of hospital services and eliminate duplication through the clear classification of hospitals.
- Work with the federal government to ensure adequate funding of Medicare.

Hospital Services In Saskatchewan



Note: Uranium City not shown ✚ Stony Rapids under construction H
Climax, Shaunavon and Eastend are a combined coverage area. Emergency services are consolidated at Shaunavon hospital during weekends.
At time of publication, Ponteix was not operating on a 24-hour basis due to staffing issues.